7-29-2022

Supporting Post-Secondary Implementation of Recovery-Oriented Practice in a Stepped Care Model

Janis Campbell
Western University, JCAMP285@uwo.ca

Abstract

Student mental health has been a growing concern for higher education communities for many years. Campuses have been struggling to keep up with the increasing demand for services which has been complicated further by the COVID-19 pandemic. A Stepped Care model (SCM) developed at a Canadian university has been offering new ways of organizing mental health resources based on open access, student choice, and recovery principles. There are diverse definitions of recovery in the literature and are usually based on values such as empowerment, respect, and self-determination. SCMs have been shown to increase access to resources and reduce or eliminate waitlists for supports. A Canadian non-profit organization, Stepped Care Consulting Group (SCCG, pseudonym) has been supporting the implementation of SCMs on campus communities in North America through training and consultation. The paradigm shift from the dominant biomedical model of health, which is expert-driven and focused on pathology, to recovery-oriented practices is complex. Currently, SCCG does not have a detailed vision of recovery-oriented practice in SCMs and limited resources to support its implementation. This problem of practice to be addressed is the lack of visioning and strategic planning for recovery-oriented practice in SCMs being implemented in post-secondary settings. Possible solutions including visioning, and resource and training development are explored. A change implementation plan is discussed along with monitoring and evaluation and communicating the change process. This plan offers practical solutions to support SCCG in moving toward a unified vision of recovery in SCM, and tools to support its implementation in post-secondary contexts.

Keywords: recovery, recovery-oriented practice, post-secondary, student mental health, stepped care

Executive Summary

This Organizational Improvement Plan (OIP) discusses recovery-oriented practices in a stepped care model (SCM) that is implemented in post-secondary settings. Chapter 1 introduces readers to the problem of practice, the organizational context in which the work is happening, the broader context of recovery-oriented practices in mental health, the conceptual framework and leadership approaches that guide this OIP, organizational change readiness, and a vision for change. Recovery-oriented practices are defined in this paper as dynamic and individual processes that focus on hope, strengths, identity, meaning, autonomy and self-determination (Slade & Wallace, 2017).

The organization discussed in this OIP has been anonymized and given the pseudonym Stepped Care Consulting Group (SCCG). SCCG is a non-profit mental health system consulting organization working in a 100% digital workspace with staff and consultants spanning Canada and the United States. The stepped care model (SCM) discussed in this OIP is a specific version that was reimagined and first implemented in a small Atlantic Canadian university and has grown in popularity in higher education and government settings. This SCM offers a new way of organizing mental health systems that is recovery-oriented and based on client autonomy, readiness, and choice (Cornish, 2020). It has been shown to reduce or eliminate service waitlists and decrease many barriers to access (Mental Health Commission of Canada, 2019).

Student mental health is an ongoing concern for most post-secondary organizations in North America and has been exacerbated by the COVID-19 pandemic which has caused illness, high levels of stress, and barriers to accessing services (Linden & Stuart, 2020). SCM has been widely recommended to address these concerns while making the mental health system more accessible to students (Mental Health Commission of Canada & Canadian Standards Association, 2020). My role within SCCG is to lead recovery-oriented practice implementation through training, resource development, and consultation. I am working from a

conceptual framework that is based on an integration of social constructivism, systems and empowerment theories, and my leadership lens which is a combination of authentic and servant leadership approaches. The problem of practice to be addressed is the lack of strategic visioning and planning for recovery-oriented practice in SCMs being implemented in post-secondary settings. For the purposes of this OIP, strategic visioning refers to a process of imagining a preferred future state and the goals and actions that will achieve it (Madsen & Ulhøi, 2021). SCCG acknowledges the need for development in this area which is part of why my position was created.

Chapter 2 offers a deeper discussion about recovery in mental health, and my combined authentic and servant leadership approaches. The relational transparency of authentic leadership (Gardner & Carlson, 2015), and the humility and respect for the people we serve (Sousa & van Dierendonck, 2015) fit well with recovery principles such as help seeker empowerment and self-determination. They also fit my personality and core values of respectful collaborative work, hope, transparency, and the empowerment of others.

An exploration of possible solutions to address the problem of practice is discussed and includes maintaining the status quo, continuing resource development and training, focusing on the internal context of SCCG, supporting a recovery-oriented workplace, and building on research and visioning of recovery in SCMs. Possible solutions are evaluated based on their viability, resource needs, whether they are in my scope of influence, and if they align with SCCG values and my leadership approach. I chose to combine two solutions to address the problem of practice; building on research and visioning combined with continued training and resource which are complimentary to each other. I then discuss the ethics, equity, social justice, and decolonization challenges related to recovery and organizational change.

Chapter 3 details the implementation, evaluation, and communication of the change process. To address the preferred solution to the problem of practice, I have chosen Kotter’s

(2012) change path model in combination with plan, do study, act (PDSA) cycles. The rationale for this is to add flexibility and rigor to the plan by using a specific process to guide the overall change and embedding PDSA cycles for ongoing monitoring and evaluation. The change implementation plan is organized around Kotter's (2012) eight stages with the assumption that it can be used as an iterative and flexible process. PDSA cycles will be embedded within and between Kotter stages to support the monitoring and evaluating functions of the change. The communication strategy will also be organized around the Kotter stages to meet the needs of each part of the implementation plan. Communication strategy and tactics will be planned before the change process starts with enough flexibility to adapt to the changing needs of SCCG personnel.

At the end of chapter 3, next steps and future considerations are discussed. After the change implementation plan is executed, SCCG should consider the key learnings from the one-year cycle of change. Now that we will have a vision for recovery in SCM, along with implementation resources, we will be able to integrate it into other SCM systems. Future research could include measuring the efficacy of recovery implementation tools at post-secondary SCM implementation sites and exploring the impact on recovery in SCMs may have on decolonizing research.

Future considerations include a focus on building bridges between the mental health recovery and substance use recovery communities to work together on our common ground. Co-authoring articles or research with my peers from the substance-use communities could contribute to this work. Lastly, I believe we need to deconstruct the language of recovery as it has diverse and complex meanings in the mental health space. The term recovery often implies that a person is recovering from an illness which only supports the bio-medical model of health that tends to disempower help-seekers.

Acknowledgements

To Terry for loving and supporting me and my ambitious ideas. I love our little family! We both just completed graduate degrees in different provinces during a global pandemic and are still married. It's vacation time.

To Jack and Amelia for bringing me the most auntie joy at all the right moments with their shenanigans.

To my supervisor and mentor, Dr. Scott Lowrey, for guiding, pushing, creating an environment for my best work to emerge, and all the tears of laughter along the way.

To the Faculty of Education instructors at Western whom I have had the honour of learning from.

To the Higher Education Cohort and 652 Crew, you have been my joy throughout the entire process. It has been an honour to walk beside you.

To my Stepped Care mentors: Dr. Heather Hair, Dr. AnnMarie Churchill, Dr. Gillian Berry, Dr. Peter Cornish, and Dr. Alexia Jaouich for their support and the privilege of having meaningful work.

To my PhD Lady Squad: Dr. Linda Jewell for solving my weird formatting problems, proofreading, and other related duties, Dr. Julia Wheeler for the lattes and sympathetic nods, and Dr. Elizabeth Cawley, my true peer and student mental health champion.

To all the friends and good humans who have supported me along my journey you are too many to count.

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Glossary of Terms

Client-Centric Care: An approach to care that considers the unique needs, preferences, and decision-making power of persons using a mental health service (Cornish, 2020).

Co-design: A dynamic and inclusive process where members of key stakeholder groups, including persons with lived experience of mental health challenges, collaborate in the development, implementation, and evaluation of programming, interventions, or care systems in mental health (Bell et al., 2021).

E-Mental Health: The use of the internet and other digital technology to deliver mental health care and information (McGrath et al., 2018).

Mental Health Promotion: Involves prevention and advocacy efforts that are aimed at improving psychological wellbeing (World Health Organization, 2021b).

Lived Experience: Persons with direct, experiential knowledge of a mental health or substance use issue (Provincial System Support Program, 2019).

Mental Health: Mental health is a state of wellbeing in which an individual realizes their own abilities, can cope with the normal stresses of life, can work productively, and is able to contribute to their communities (World Health Organization, 2021b).

Peer Support: A supportive, mutual helping relationship between two or more people with a lived experience in common (Sunderland & Mishkin, 2013).

Recovery: A dynamic and individual process with a focus on hope, identity, meaning, autonomy and self-determination. This differs from the concept of clinical recovery, which is considered an observable, concrete outcome that is the same for everyone, and evaluated by clinicians

Recovery-Oriented Practice: A diverse set of principles, values, and practices that aim to empower persons with lived experience of mental health challenges, their families, and communities. Themes of recovery-oriented practice include holistic, client-centric care, inclusion, social-determinants of health, recovery being a highly personal and unique process,

and a focus on empowerment, autonomy, and self-determination (Mental Health Commission of Canada, 2015).

Strategic Visioning: A process of imagining a preferred future state and the goals and actions that will achieve it (Madsen & Ulhøi, 2021).

Stepped Care Model (SCM): A flexible, recovery-oriented framework of organizing mental health and addictions systems (Cornish, 2020). The SCM promotes open access to a variety of service options of varying intensities and modalities based on client readiness, autonomy, and choice.

Wellbeing: A state of happiness and contentment, with low levels of distress, overall good physical and mental health and outlook, or good quality of life (American Psychological Association, 2021).

Chapter 1: Introduction and Problem

Student mental health continues to be an actively discussed issue in post-secondary institutions. Leadership has struggled to meet the increasing demand for mental health and counselling services which has resulted in long waitlists and other barriers to access (American College Health Association, 2019; Cage et al., 2018). Mental health administrators have often hired more counselling professionals to meet the demand with limited success. The problem is more complicated than a supply and demand issue.

Stepped Care Models (SCM) are becoming increasingly popular in post-secondary environments because they provide a different approach to organizing mental health resources that offer quick access to a variety of formalized and informal supports of different treatment intensities based on student autonomy, readiness, and choice (Cornish, 2020; Cornish et al., 2017; Mental Health Commission of Canada, 2019). This Organizational Improvement Plan (OIP) will discuss a specific model, but to protect the identity of the organization, this model will be referred to as SCM. The SCM principles and core components are rooted in recovery-oriented practice. Recovery-oriented practice can be defined as a diverse set of principles, values, and practices that aim to empower persons with lived and living experience of mental illness, mental health concerns, their families, and communities. Themes of recovery values include holistic, client-centric care, inclusion, social-determinants of health, recovery being a highly personal and unique process, and a focus on empowerment, autonomy, and self-determination (Mental Health Commission of Canada, 2015).

This OIP helps address a specific problem of practice related to student mental health programming and services in the context of post-secondary institutions that have or are in the process of implementing SCM which is visually depicted in Appendix A. It will focus on a consulting organization that works with post-secondary institutions who are implementing SCM. System-level changes and promoting a paradigm shift toward recovery-oriented practice require research-informed training and tools, along with a comprehensive implementation plan. In

chapter 1, I will discuss my organizational context, leadership position and lens, problem of practice, questions arising from this problem, leadership vision for change, and organizational change readiness.

Organizational Context

The following section will discuss the different aspects of my organizational context which includes a broad view of political, economic, social, and cultural factors, the theoretical frameworks that guide my work, how these contextual factors shape the work, and the vision of our organization.

Organizational Overview

I work for a non-profit organization that aims to promote wellness through the transformation of mental health systems. We work collaboratively with organizations and key stakeholders to improve access and promote flexible services through implementing SCM. This model (Appendix A) is a reimagined version of stepped care models that were developed in the United Kingdom and from the work of O'Donohue and Draper (2011). It is a flexible, recovery-oriented framework for delivering mental health services to increase access to multiple levels of care (Cornish, 2020; Cornish et al., 2017). The SCM promotes open access to a variety of service and resource options of varying intensities and modalities based on student readiness, autonomy, and choice. It includes guiding principles (Appendix A), and core components (Appendix B) that reflect student-centric, recovery-oriented care. For the purposes of this OIP, I will use a pseudonym and refer to my workplace as Stepped Care Consulting Group (SCCG) and a pseudonym for the stepped care model (SCM) that we use. SCCG works in a consulting role with provincial and federal government agencies in Canada, and post-secondary institutions in Canada and the United States.

SCM has its roots in an Atlantic Canadian province where it was developed in a post-secondary setting, and then scaled up to a provincial health care system. SCCG began as a few like-minded professionals working to improve mental health service delivery for university

students by implementing SCM. In the spring of 2020, SCCG became a non-profit organization that has approximately 30 employees, subject-matter experts, faculty, and consultants. SCCG has a wide range of expertise from across North America including mental health professionals, researchers, data analysts, technology and e-mental health experts, marketing and communications professionals, administrators, and other leaders in the field. Everyone at SCCG works remotely and while I am located in Atlantic Canada, most of my colleagues are in different communities spanning Canada and the United States.

SCCG's mandate is to lead mental health system transformation by providing guidance and inspiration to organizations that are working to build mental health service systems that prioritize open access and flexible care. SCCG's values include synergy, open collaboration, adapting and learning, compassion and empathy, Diplomatic disruption, and impact. Building synergy through open collaboration in SCM is often done via co-design. Co-design can be described as a dynamic and inclusive process where members of all key stakeholder groups collaborate in the development, implementation, and evaluation of programming, interventions, or care systems in mental health (Hodson et al., 2019). O'Cathain et al. (2019) make the important distinction of highlighting the active involvement of persons with lived experience and other key stakeholders in the design, development, and improvement of health and social services in their definition of co-design. This is important because co-design is more than consultation with stakeholder groups. It is an active, ongoing, and iterative process where all key stakeholders, including service users, have equal power and voice.

SCCG values continuous learning which has resulted in the ongoing revision of the framework. As the organization grows and develops new partnerships, the ideas continue to grow and improve. SCCG leadership often use the term *diplomatic disruption* which refers how we partner with supporters and criticizers of our work, and other organizations. Diplomacy refers to the "skill in the management of relations of any kind; artful management in dealing with others" and disruption is defined as "The action of rending or bursting asunder" (Oxford

University Press, n/d). Our founder and president often uses the phrase *diplomatic disruption* in relation to our work, and said that in order “to succeed with bold transformation, support through the anxiety, fear, discomfort, confusion, uncertainty, anger, resistance associated with the change process is crucial” (Cornish, 2021). We acknowledge these challenges with empathy but choose the term diplomacy because it implies empathetic support and steadfastness. SCCG works in collaboration with stakeholders to find solutions where everyone can win even if there are differences in priorities and values. We expect there to be differences and challenges and work within them. It is important to note that SCCG welcomes challenges and being diplomatically disrupted ourselves. It is what leads to continuous improvement, and to building trusting and authentic relationships with others.

Political, Economic, Social, and Cultural Contexts

Student mental health is an ongoing concern of post-secondary institutions in North America as the demand for services continues to increase (American College Health Association, 2019; Linden et al., 2018). The public appears to be paying more attention to the perceived student mental health crisis (American College Health Association, 2019). Student advocacy groups are vocal about their concerns, and public media attention particularly after a student death by suicide puts immense pressure on the institution (Mancini & Roumeliotis, 2019). While it may be tempting to focus on individual risk factors contributing to poor mental health, we must also consider interpersonal and institutional level factors if we are to have a complete picture of such a complex problem (Byrd & McKinney, 2012). Additionally, the COVID-19 pandemic created a significant increase in the interest of e-mental health resources such as web-based self-help resources, virtual counselling, and virtual support groups. SCCG had already been working within e-mental health (Mental Health Commission of Canada, 2019), and exploring the digitization of SCMs through a Canadian Institutes of Health Research project. Our organization was well-equipped to support the transition of services online and encouraging rethinking of the organization of health systems.

In addition to the above-mentioned factors, the Spring of 2020 brought the COVID-19 pandemic which came with new and unprecedented challenges that resulted in approximately four billion people around the globe suddenly having to live in isolation, which only exacerbated mental health challenges (Sanford, 2020). The mental health of young people had already reached what many describe as epidemic levels before the pandemic (Landau, 2020). In March of 2020, post-secondary institutions shut down and transitioned all classes and student services online while at the same time requesting students to return home. Suddenly, students, faculty and staff were adjusting to working remotely from home while balancing work/life responsibilities. Many students lost jobs and work placement opportunities, social connections, and access to confidential support services that did not transition well online (Rashid & Genova, 2020).

The National Institute for Health and Care Excellence has recommended stepped care models in their clinical practice guidelines because they have been shown to improve access to and optimize resources for common mental illnesses such as anxiety and depression (National Institute for Health and Clinical Excellence, 2009, 2011). SCMs have also demonstrated positive rates of recovery for common mental health disorders such as anxiety and mood disorders (Firth et al., 2015; Gyani et al., 2013). One of the reasons that SCM has become so popular in North American post-secondary institutions is that it reduces or eliminates service wait times (Mental Health Commission of Canada, 2019). It is also cost-effective because the organization of the model uses resources more effectively. Mental health care is chronically underfunded and post-secondary institutions in the neoliberal era are highly concerned about shrinking budgets. While cost-effectiveness is not SCCG's primary concern, it has attracted many organizations to SCM which has allowed for our system change work to continue. This is a contextual factor that is kept in mind as we do our work.

Organizational Theory

SCCG is still a new organization that is navigating rapid growth in a constantly changing environment. SCCG's organizational values are to create innovative solutions to promote mental health systems change that are grounded in recovery-oriented practice and SCM principles (Appendix A). As an organization, we aim to practice the same recovery principles that are woven throughout the framework ourselves. SCCG has grown so quickly that it has had to continuously adapt to new realities. For example, the COVID-19 pandemic brought on a significant interest and need for e-mental health and digital SCM platforms which resulted in SCCG rapidly scaling up work that was underway through several other projects. The increasing need for SCM to be applied in larger contexts meant that SCCG have continuously hired new talent to meet the demand which has been a continuing and evolving process.

While identifying a theoretical framework for the SCCG is challenging due to factors such as rapid growth, the new science paradigm offers some insight. Also known as post-positivist, the new science paradigm assumes that organizations are complex, interrelated, wholistic, and exist in uncertainty (Manning, 2017). Zohar (1997) defined post-positivism and articulated characteristics of the new science paradigm that I see reflected in SCCG. For example, the connection of the mind, body and spirit, interrelatedness, trust, non-linear and multiple realities are all present in the work of SCCG through recovery-oriented practices.

The new science perspective always brings me back to reflecting on how the challenges of student mental health systems can not be simplified as a supply and demand issue. SCCG is a value-driven organization. Wheatley (2006) encourages us to see interconnectedness and systems rather than isolated and individual: "We live in relationship, connected to everything else; we are learning that profoundly different processes explain how living systems emerge and change" (p. 158). These ideas manifest in SCCG in our discussions about synergy. The Oxford Dictionary defines synergy as "the interaction or cooperation of two or more organizations, substances, or other agents to produce a combined effect greater than the sum of their separate

effects” (Oxford University Press, n/d). We intentionally promote synergy in SCCG with a recognition that we are better and do better when we work collaboratively in this manner. While much of the new science literature was written approximately 15 years ago, the ideas continue to grow in different ways. For example, newer conceptualizations include humanistic, cultural, systemic and holistic ideas (Cynarski, 2014).

Recovery is an individual, complex, and non-linear process and is the foundation of SCM. SCCG also tends to invite collaboration with other organizations rather than be competitive. I also see elements of the spiritual frame in our organization. This frame embraces positive psychology which aligns recovery-oriented practice by challenging the deficits-based medical model (Manning, 2017). SCCG leadership has worked hard to create an environment that promotes psychological health and encourages individual and collective pursuits of meaningful work, and self-actualization. The following section will discuss my own leadership lens, positionality, and conceptual framework.

Leadership Position and Lens

The following section will discuss my leadership position and lens within SCCG. This includes a conceptual framework, my personal leadership positionality in the organization, leadership approach, and my role in the change process.

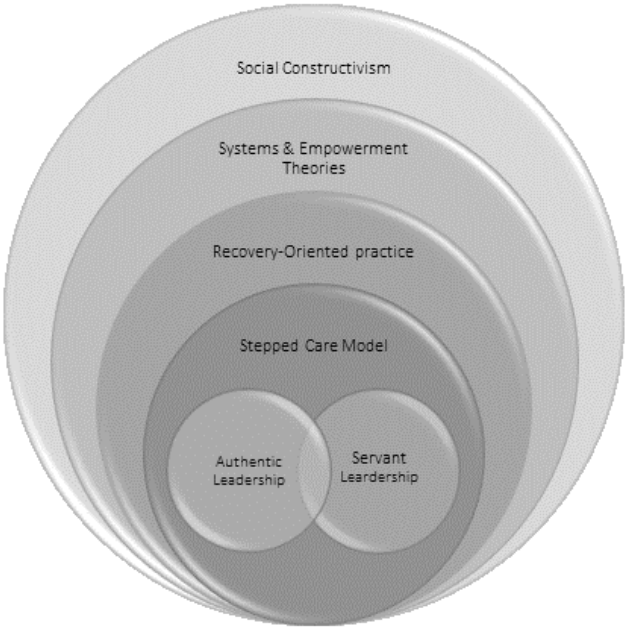
Conceptual Framework

The conceptual framework for this OIP consists of social constructivism, systems theory, empowerment theory, recovery-oriented practice, and the SCM in combination with my authentic and servant leadership approaches (

Figure 1). I have embedded my theoretical framework within the conceptual framework which includes social constructivism, systems theory, and empowerment theory.

Figure 1

Conceptual Framework



Social constructivism falls within Burrell and Morgan's (1979) interpretivist paradigm which seeks to understand the world as it is through the lens of subjective experience. Social constructivism is a term that refers to several theories that are based on the idea that knowledge and reality are socially constructed, and individuals learn and make meaning from each other and their environments (Berger & Luckmann, 1966; Cottone, 2007). The belief is that knowledge is "created by people and influenced by their values and culture" (Scheurman, 2018, p. 101). In mental health and recovery-oriented practice, it is crucial that we consider the help seeker's perspectives, the context in which they live, and how these factors impact their health and wellbeing. Ignoring these factors will only continue to promote the biomedical model of health and systemic oppression.

Theoretical Framework

Within a social constructivist framework, I am drawing from ecological systems theory (Bronfenbrenner, 1979) and empowerment theory (Liu & Wang, 2021; Rappaport, 1981, 1987; Rappaport, 1995). Ecological systems theory identifies the complex interplay between the

individual, interpersonal, institutional, community, and social system factors that impact mental health, and has been used in several mental health policy documents including the recent Standard for Psychological Health and Safety of Post-Secondary Students (Mental Health Commission of Canada & Canadian Standards Association, 2020). The current bio-medical model that dominates our health system focuses primarily on what is wrong with an individual and attempts to fix or cure it. Clinicians working in this model focus on diagnosing the problem and managing the behavioural symptoms associated with it. Much of the time, this approach fails to consider the context of peoples' lives, their perspectives, experiences, cultures, and the interactions of these systemic elements on a person's health. These elements are commonly referred to as the social determinants of health (Allen et al., 2014). Biomedical models of health view mental distress as a brain disease and although many believe this is scientifically objective, simplifying mental distress in this way rather than considering factors such as social, racial, cultural, economics, class systems, only serves to perpetuate stigma and oppression of certain groups (Allen et al., 2014).

In addition to Bronfenbrenner's work, I am basing my systems theory framework on Keyes' mental health dual continuum, and the concepts of flourishing and languishing (Keyes, 2002). This approach also considers biological and psycho-social factors. Keyes tells us that mental health is not simply the absence of mental illness, but it is inclusive of multiple dimensions such as mental, physical, social, cultural, and spiritual aspects. For example, people experiencing mental illness can flourish even if they have ongoing symptoms. Similarly, people who do not have a mental illness can experience languishing and poor mental health (Keyes, 2002). The belief that persons experiencing mental health problems are resilient and can live meaningful lives even if they are experiencing symptoms is a foundational concept of recovery.

Empowerment is a product of learned hopefulness (Zimmerman, 1990) and can be defined in mental health as "the level of choice, influence and control that users of mental health services can exercise over events in their lives" (World Health Organization, 2010, p. 2).

Rappaport (1987) states that empowerment is more than an individual construct and it can take different forms for different people or in different contexts (Zimmerman, 1995). Galiè and Farnworth (2019) state that “empowerment can equally be understood as a multi-dimensional process that perforce entails social relations among individuals, groups of people, and institutions” (p. 13). Empowerment is also political, organizational, economic, sociological, and spiritual. Empowerment theory is grounded in the belief that it is possible for people to have autonomy, self-determination, power, and control over their lives (Zimmerman & Rappaport, 1988). This lens does not view people as one thing or identity; rather, it views them through a holistic lens that considers the complex and intersecting identities of individuals and groups. Empowerment theory is common in mental health practice and research. For example, Liu and Wang (2021) found that the empowerment process in a digital mental health community setting had positive impacts on service user self-efficacy. Self-efficacy can be defined as a person’s belief in their own capabilities and realizing control of their own lives (Bandura, 1997). Self-efficacy is directly related to empowerment and positive mental health (Liu & Wang, 2021).

Dr. Patricia Deegan wrote a seminal paper in 1988 that discussed the difference between the ideas of recovery and rehabilitation in the context of persons with psychiatric disabilities. She is a person with a diagnosis of Schizophrenia, a clinical psychologist, and a recovery pioneer. Deegan (1988) argued that “disabled persons are not passive recipients of rehabilitation services. Rather, they experience themselves as recovering a new sense of self and of purpose within and beyond the limits of the disability” (p. 11). Deegan’s definitions of rehabilitation and recovery were ground-breaking for their time and are still relevant today:

> Rehabilitation refers to the services and technologies that are made available to disabled persons so that they might learn to adapt to their world. Recovery refers to the lived or real-life experience of persons as they accept and overcome the challenge of the disability. (Deegan, 1988, p. 11)

Even though this paper was discussed in the context of persons experiencing psychiatric disabilities, Dr. Deegan continues to lead a broader, global movement of recovery and contributes significantly to the academic literature (Deegan, 2020; MacDonald-Wilson et al., 2021). Other conceptualizations of recovery that have informed this paper include the Substance Use and Mental Health Services Administration (SAMHSA) principles (Substance Use and Mental Health Services Administration, 2010), and the Mental Health Commission of Canada (MHCC) recovery guidelines (Mental Health Commission of Canada, 2015). These conceptualizations are discussed further in chapter 2.

The guiding principles of SCM assume that an individual knows what is best for themselves, experts do not hold all of the wisdom, and all individuals and communities have strength and capacity (Cornish, 2020). SCM systems also value co-design where members of key stakeholder groups work collaboratively. (Bell et al., 2021). These groups can include people with lived experience, peer supporters, mental health providers, management, leadership, families, and other community members. Co-design has the potential to benefit stakeholders and can ensure that the mental health system truly represents their communities.

Peer supporters and other people with lived experience of mental health challenges have a crucial role to play in an SCM and represent one of the five key stakeholder groups identified in the *SCM Implementation Guide.* Peer Support can be defined as a supportive, mutual helping relationship between two or more people with a lived experience in common (Sunderland & Mishkin, 2013). This can include informal peer-to-peer support, and more formalized services delivered by trained peer supporters. Peer supporters are leaders and role models of empowerment and recovery. Peer supports create community and inclusivity have much to offer the SCM system transformation process with their experiential knowledge and lived experience perspectives. Many colleges and universities hire or recruit student volunteers to support other students in a peer helping relationship (Carrasco, 2022). This practice is increasing especially as post-secondary institutions in Canada are implementing

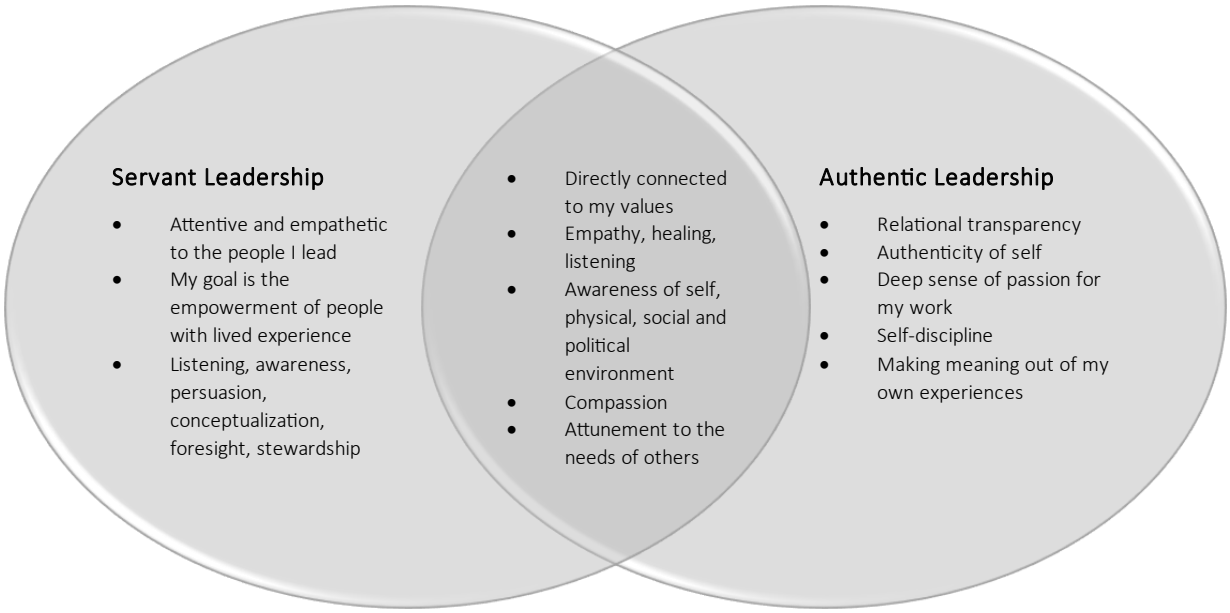
recommendations from the Psychological Health and Safety Standard for post-secondary students (Mental Health Commission of Canada & Canadian Standards Association, 2020).

Authentic and Servant Leadership

I have embedded my approach to leadership in my conceptual framework as shown in Figure 1. I draw from authentic and servant leadership approaches in my work as shown in Figure 2.

Figure 2

Leadership Approach



At my core, I offer genuine, lived experience leadership. I have developed unique perceptions and skills that have led to the development of my authentic/servant leadership style (Avolio & Gardner, 2005). One of my core values that I try to model is relational transparency which is essentially about showing my true self to others (Northouse, 2018). If I were being observed in action, I would demonstrate many of the characteristics of an authentic leader as defined by George (2003) including a deep sense of purpose, self-discipline, passion for my work, empathy toward others, and creating trusting relationships. I have built on my self-

awareness, self-knowledge, and self-concept by living my own recovery journey. Making meaning out of experiences can be a big part of a person's recovery pathway that is unique to the individual (Mental Health Commission of Canada, 2021a). Gaining insight and self-knowledge from critical life events and sharing one's story can make one a more authentic leader (Luthans & Avolio, 2003). Major events in my life have given me the opportunity to grow in ways that have made me a stronger, wiser, and more authentic leader.

I entered a helping profession because I wanted to serve others, and this has become a value that grounds all the work that I do. Greenleaf (1973) is the seminal author of the servant leadership approach and states that a leader is a servant first, and has social responsibility to those with less privilege in society (Northouse, 2018). I demonstrate many of the behavioural characteristics that Greenleaf discussed that were clarified in the writing of Spears (2002). These include, listening, empathy, healing, awareness, persuasion, conceptualization, foresight, and stewardship. Sendjaya (2015) defines servant leadership as

> A holistic approach to leadership that engages both leaders and followers through its (1) service orientation, (2) authenticity focus, (3) relational emphasis, (4) moral courage, (5) spiritual motivation, and (6) transforming influence such that they are both transformed into what they are capable of becoming. (p. 1)

There is literature that discusses the importance of servant-leadership approaches in healthcare for the benefit of the providers and patients (Trastek et al., 2014), in the workplace environment, and at the system level (der Kinderen et al., 2020). Servant leadership offers health care providers qualities and opportunities that promote recovery-oriented practice in a system that is transactional and problem-focused in nature. Servant leadership also fits within the new science paradigm as it values collaboration, community, and shared decision-making (Spears, 2004).

The authentic leadership approach describes my internal qualities and processes, while the servant leadership approach complements it with an empathetic, outward focus on others.

Both approaches are deeply grounded in my values of empathy, compassion, respect, and understanding of others. Both approaches require highly developed listening skills, and for me to be attuned to the people and environment around me while considering multiple, intersecting factors in my work.

Positionality and Role in the Change Process

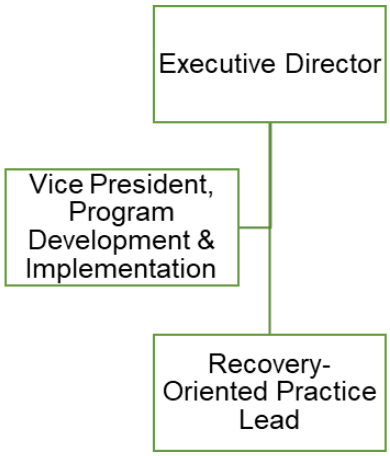
I engage in my work through the lens of multiple, intersecting identities. I am a professional counsellor and educator. I am a white, female-identifying, able-bodied, employed person who can afford housing and the necessities of life. I am also a person with living experience of mental health disability that impacts my daily life and ability to thrive. I have many privileged identities and some vulnerable identities. It is not common for a mental health professional to disclose their own personal experience with mental health struggles, and I have experienced criticism and discrimination within my professional and personal lives for embracing this side of my identity. I am grounded in recovery-oriented practice in a very experiential way that offers a unique lens to the work I do. I hold positions of power and vulnerability at once. Being on my own recovery journey makes me good at what I do, and having meaningful, impactful work continues to be a major part of my healing process. I have a strong desire to leave things better for the people coming up behind me.

I am the Recovery-Oriented Practice Lead for SCCG, and I am responsible for work in the areas of recovery and peer support in SCM. I also contribute to the areas of co-design, diversity, equity, and inclusion, as well as training and implementation of the model. Much of my work involves developing education, toolkits, and other knowledge exchange products to support the implementation of SCM in various post-secondary settings in Canada and the United States. I also deliver training and consultation to these organizations to support their implementation teams particularly in the areas of recovery-oriented practice, peer support, and co-design. I report to the Senior Vice President of Implementation as the subject-matter expert on peer support and recovery, and I have freedom to develop tools that support SCM

implementation in these areas. SCCG leadership has decided not to share a formalized organizational chart (M. Bartlett, personal communication, July 20, 2022). Figure 3 illustrates my direct reporting line within the organization. The following sections discuss the leadership problem of practice that this OIP is addressing.

Figure 3

SCCH Direct Reporting Chart



Leadership Problem of Practice

Post-secondary institutions in Canada have been struggling to meet the increasing demand for student mental health supports which has led to innovative service delivery system changes such as the SCM. The overall goal of SCM is to offer students quick access to a variety of services and supports based on their level of readiness and choice (Cornish, 2020). Many Canadian campuses have implemented SCM and made commitments to creating healthy campus communities. Over 30 Canadian colleges and universities have joined the Canadian Health Promoting Campuses Network which endorses the Okanagan Charter, an international charter for health promoting colleges and universities (International Conference on Health Promoting Universities and Colleges, 2015). The charter has two calls to action: to embed health into all aspects of campus culture, across the administration, operations, and academic mandates; and to lead health promotion action and collaboration locally and globally. SCM is

grounded in recovery-oriented practices that promote hope, autonomy, and empowerment through organizing both professional, and non-clinical services that support the mental health of service users (Cornish et al., 2017; Cornish et al., 2020). In the past, institutions have hired more professional mental health staff to address the increasing demand (Cornish et al., 2017) but we are now seeing a move towards healthy campus communities and more non-clinical resources available to students (Linden & Stuart, 2020).

The effects of mental health issues are broad and can negatively impact a student's personal and academic functioning (Keyes, 2007; Linden et al., 2018; Linden & Stuart, 2020). For example, many students report high levels of distress but will never set foot in a mental health clinic for a variety of reasons such as stigma and not believing their problem warrants professional service (Linden et al., 2018). Students are more likely to reach out to their peers (Brill, 2015) when they need help making it crucial for leadership to invest in peer support programming in a systemic and sustainable way that fits within SCM and recovery-oriented practice.

Mental health administrators invest a lot of time and money into training professional counselling staff in the SCM core components such as one-at-a-time thinking though single-session therapy, but often struggle with the broader, radical system changes that come from moving away from the biomedical model to recovery-oriented practices even though the intention of SCM is to change the whole care delivery system and promote a healthy campus community for all. These are important contextual factors SCCG needs to consider as we continue our work in higher education. Currently, SCCG has little training or implementation resources available for recovery-oriented practice that integrate SCM principles and core components in a post-secondary context. SCCG also does not currently have a unified vision of what recovery is and how it fits into SCM.

The problem of practice to be addressed is the lack of strategic visioning and planning for recovery-oriented practice in SCMs being implemented in post-secondary settings. To

achieve the cultural and system change required by SCM for recovery-oriented practice, SCCG needs an overall vision, strategic plan, and investment in building recovery-oriented practice tools, guides. Implementation plans are needed and must be inclusive of the model's principles, and core components.

Framing the Problem of Practice

This section will discuss the problem of practice in a broader context. It includes a discussion about why change is needed, historical overview, recent literature on recovery-oriented practice, and the role of equity, decolonization, and social justice in mental health.

Historical Overview of Recovery

Recovery has its roots in social justice via the consumer-survivor movement in Canada and the United States. In the mid-twentieth century, the movement started as a reaction to the deinstitutionalization process (Mental Health Commission of Canada, 2015). For decades before, mental illness and people living with other disabilities were hidden away in institutions such as state-run public mental hospitals and asylums. Many of these people suffered severe abuse and neglect as these institutions became overcrowded and underfunded (Wright & Moran, 2006). Deinstitutionalization refers to the process of the closure of state mental institutions, and transfer of care to community mental health services (Shen & Snowden, 2014). Unfortunately, poor planning and lack of appropriate resources led to many persons living with mental illness ending up in prison, homeless, and pushed to other fringes of society.

The grassroots consumer-survivor movement, also referred to as the psychiatric survivors or ex-patients' movement, grew in response to a failed mental health system and gained momentum in the 1970s and 1980s (Mental Health Commission of Canada, 2015). This movement "rejected the medical model's discourse and seeks to reconnect individual psychological suffering with social, political, economic, and environmental conditions of oppression and injustice" (Adame & Leitner, 2008, p. 148). Alternative ways of healing, such as peer support, grew in this time as people with lived and living experience of mental health

challenges came up with collaborative, person-centered approaches for helping each other. Recovery is also a central tenet of self-help groups for substance use such as Alcoholics Anonymous or Narcotics Anonymous (Mental Health Commission of Canada, 2015).

While recovery is still connected to its social justice roots, it has evolved over time. There are now many conceptualizations of recovery but no one definition that is used commonly. Many definitions have concepts in common such as individualized and person-centered care, and experiences of empowerment, self-determination, purpose, and hope (Ellison et al., 2018). For the purposes of this discussion, recovery is defined as a dynamic and individual process with a focus on hope, identity, meaning, and personal autonomy. This differs from the concept of clinical recovery, which is considered an observable, concrete outcome that is the same for everyone, and evaluated by clinicians. Clinical recovery is aligned with the biomedical model of healthcare while personal recovery is aligned with recovery-oriented practice (Slade & Longden, 2015). It is important that we have a clear message and definition of what we mean when we say recovery in SCM, and we cannot assume that others working in the mental health system have the same understanding.

Current Context of Student Mental Health

Student mental health is an ongoing and visible priority for most post-secondary institutions in North America (American College Health Association, 2019). Students ages 18-30 who make up a significant portion of most post-secondary populations, are vulnerable to mental health issues due to several factors including increased workload, academic pressure, moving away from home for the first time, managing family and life responsibilities (Kruisselbrink Flatt, 2013). The modern student now faces a number of unprecedented challenges including taking on significant debt to fund their studies (Pisaniello et al., 2019), and transitioning to an increasingly complex workforce (Kyndt et al., 2017). In addition, 2020 brought the COVID-19 pandemic which came with new and unprecedented challenges that resulted in approximately

four billion people around the globe suddenly having to live in isolation which only exacerbated mental health challenges (Sanford, 2020) and increased stress globally.

In March of 2020, post-secondary institutions shut down and transitioned all classes and student services online while at the same time, requesting students to return home. Suddenly, students, faculty and staff were adjusting to working remotely from home while balancing work/life responsibilities. Many students experienced delays in their programs, social connections, and access to in person supports (Rashid & Genova, 2020). At the time of writing this chapter, some student mental health services are transitioning back to in-person care, and many are blending modalities. We are seeing more acceptance and use of e-mental health tools like self-help programs, apps, and counselling by video or telephone. The student mental health landscape will continue to evolve, and it is important to stay connected to internal and external factors that impact the whole system of care.

Recovery, Power, and the Risk Paradigm

Recovery-oriented practice is about a shift in power to the help-seeker and a belief that people can live well whether or not they have symptoms of mental illness (Lorien et al., 2020) In the current medical model, all the power lies with the mental health professionals and leadership. Power is embedded in the system through policies and positionality and perpetuates oppression of those who do not have it. Power is also in the hands of individual clinicians who are taught to assess and diagnose mental health problems and offer treatment. In this context, there is more *power over* rather than *power with.* In a recovery-oriented system, there is a significant transfer of power from the professionals to the persons seeking help. It is puzzling that we work in a system that is supposed to empower and help people, yet we focus on what is wrong with them, and behave like they need our expert knowledge to fix it. This only serves to perpetuate the “us and them” mentality and results in disempowerment and an overburdened mental health system that is already underfunded.

Many organizations, including colleges and universities, have risk-averse cultures stemming from neoliberalism (Busch, 2017; Stanford et al., 2017). This is so prevalent that it is difficult to separate risk from the mental health discourse. Neoliberalism focuses on individual self-interest and fear of the future, which in mental health has contributed to blaming those who fail to meet society's norms. What is interesting about risk in mental health is the preoccupation with the "risks posed to others by people with a mental health problem as opposed to the risks they overwhelmingly face" (Stanford et al., 2017, p. 5). This is a much different view than in other fields of social welfare such as persons with disabilities, and the elderly where "the vulnerability of people 'at risk' is a more prominent feature" (Stanford et al., 2017, p. 5).

The complexities of these barriers to change have led me to an understanding that implementing recovery-oriented practice is a complex and ongoing process with many hurdles to navigate. I have realized that training individuals about recovery is a good start, but still insufficient. SCCG is in the process of developing a general recovery training for internal staff and for external consultations at implementation sites. The more I develop this training, the more I understand the importance of change beyond the individual level. SCM and recovery approaches require system-level change that comes from a major shift in culture. Post-secondary institutions have been shown to support risk-averse policies (Shankar & Tavcer, 2021) and what we are asking of them is a significant challenge. This is where diplomatic disruption comes into play. Risk culture is something that needs our consideration as we develop resources and implementation tools for our clients. It is inefficient just to teach staff about recovery. SCCG also needs to support the empowerment of these organizations, including leadership, management, and staff, and engage them in a process that helps with this broader shift in practices, policies, and the sharing of power.

Guiding Questions Emerging from the Problem of Practice

This section briefly discusses three guiding questions that have emerged from studying this problem of practice. The following three guiding questions will be addressed: why change

the system; why mental health promotion and recovery; and why is recovery so difficult to implement?

Why Change the System?

Some have argued that there is nothing systematic about our mental health system and because of this, external sociopolitical forces create an environment for fear, stigma, and perceived risk (Cornish, 2020; Stanford et al., 2017). Mental health services continue to be dominated by the traditional medical model which focuses on symptoms and functioning (Biringer et al., 2016). This approach to mental health care greatly benefits large pharmaceutical companies who have spent billions of dollars marketing their medications and convincing great numbers of people in our society that mental illness is a biological disease that can be managed with drugs even though there is little robust evidence to prove (Greenberg, 2010). There are other important considerations in the treatment of mental illness such as psychological and social factors (Malla et al., 2015). Pharmaceutical companies have convinced people that distress of any kind is a biochemical disease that should be treated with medication.

Persons seeking help in the medical model are often seen through a lens of brokenness and treatment is focused on fixing the problem as it is defined and assessed by a professional. The current system also has many barriers to access. For example, the Mental Health Commission of Canada (2021a) reports that 1.6 million Canadians say they have unmet mental health care needs, and one in two people have had experiences of a delay in access to services. SCM argues for a radical shift in health system culture toward recovery-oriented practice, client-centric care, and open access to a variety of services. The client-centric approach within a SCM context privileges the persons seeking help unique needs and preferences. It also prioritizes informed decision making (Cornish, 2020).

Why Mental Health Promotion and Recovery?

The World Health Organization (WHO) calls for person-centred, human-rights based, and recovery-oriented care in mental health (World Health Organization, 2021a). The WHO

defines health promotion as “comprehensive social and political processes that enable people to increase control over their health and its determinants and thereby improving their health” (World Health Organization, 1998, p. 1). The conversation on student mental health continues to go in the direction of promoting healthy campus communities for all rather than a few identified to be at risk, or with complex needs. This requires whole systems changes and a variety of person-centered options of different treatment intensities which is something SCM offers.

Recovery Sounds like a Great Idea; Why is it so Difficult to Implement?

Recently, the Mental Health Commission of Canada (MHCC) released a toolkit for recovery-oriented practice implementation (Mental Health Commission of Canada, 2021b) to address this question. In 2015, the MHCC released their *Guidelines for Recovery-Oriented Practice* which outlines six broad recovery dimensions. This includes creating a culture and language of hope, recovery is personal, recovery occurs in the context of one’s life, responding to the diverse needs of everyone living in Canada, working with First Nations, Inuit, and Métis, and recovery is about transforming services and systems (Mental Health Commission of Canada, 2015). While these guidelines were filled with well researched information, the MHCC followed up with the implementation resource with guidance and concrete examples of recovery in action in different contexts. Training in recovery is a good first step but is insufficient on its own when it comes to system-level engagement and transformation.

There is more research available about the individual and service provider level of recovery, and less on organizational and system-wide implementation levels. Recovery-oriented practice implementation needs to move beyond the frontline workforce and ensure it is “embedded in the core identity and role of mental health service providers, alongside developing an understanding of the process of change and broader systemic influences, [and] will be crucial in supporting organizational transformation” (Piat et al., 2021, p. 15). I would add that recovery implementation requires a cultural shift and needs to be embedded in organizational values in order to facilitate this kind of change.

Leadership-Focused Vision for Change

In the next section, I discuss leading change in the context of a paradigm shift in mental health care. Starting with a broader overview, the discussion then turns to leading this kind of change in a higher education system, and considerations for ethics, equity, decolonization, and social justice.

A Paradigm Shift in Mental Health Care

There has been much discussion in the mental health system literature arguing for a paradigm shift toward recovery-oriented practice. This is evident in research, policy documents, and other work such as the Mental Health Commission of Canada's *Guidelines for Recovery-Oriented Practice* (Mental Health Commission of Canada, 2015, 2021a), and the many learning resources provided by Psychosocial Rehabilitation Canada (Psychosocial Rehabilitation Canada, 2021). This paradigm shift can be much more complex than it seems. For example, individual mental health professionals who align with recovery-principles and work with clients in this way are employed by systems that are risk-averse, and medical model focused. If I am a clinician working in a context like this, I may be required by my employer to complete a suicide risk screening assessment before I even ask my client why they have come in for counselling.

SCM intentionally challenges the risk paradigm and promotes recovery-oriented practice. For example, one of the SCM core components is client-centric care. This is similar to the better known client-centered care but goes further by engaging the help seeker in the decision-making process and offering a variety of options for them to choose from (Cornish et al., 2020). Mental health professionals in this setting learn about the help seeker's perspective of the problem and work collaboratively to create a plan to address it. They can provide detailed information about the many options available and support the help seeker in making choices.

Leading the Mental Health Paradigm Shift in Higher Education

Kezar (2018) encourages leaders in higher education to approach change from what she describes as multi-frame leadership model. This idea builds on Bolman and Deal's (2017) four

frames of educational leadership. These frames are structural, human resource, political, and symbolic. While I can see the benefit of using each of Bolman and Deal's frames, I believe the political and symbolic frames will be particularly useful in my work. The relevant assumptions of the political frame include the view of organizations as coalitions that include different individuals and interest groups, coalition members have different beliefs, values, interests, and understanding of reality, important decisions often involve allocating scarce resources, and lack of resources and value differences create conflict dynamics where power is a crucial asset (Bolman & Deal, 2017, p. 184). The political frame is particularly important for me to understand in the context of post-secondary implementation of SCM. It offers insight into the landscape and nature of the implementation environment. It is also relevant because many post-secondary institutions are motivated to implement SCM because of high demand for services and scarce resources.

Bolman and Deal's (2017) symbolic frame is also useful in leading change in higher education and within my conceptual framework. The symbolic frame focuses on meaning-making, culture, multiple interpretations of events, symbols and metaphors, and organizational vision and values. SCCG is grounded in the SCM principles (Appendix A) that express our underlying value system and guide our mission to transform mental health care. SCCM leadership have a broad vision for a recovery-oriented system of care that offers help-seekers choices, autonomy, and self-determination. This vision is infused into all areas of our organization and keeps us all connected with a sense of meaning and purpose in the work we do.

Considerations for Ethics, Equity, Decolonization and Social Justice

Kezar and Fries-Britt (2020) tell us that routine efforts do not usually create change for issues of equity. "Radical-equity leaders need to be weaver-leaders to help bridge differences and bring people together into shared vision, and set expectations" (Kezar & Fries-Britt, 2020, p. 12). We cannot continue to create change in the same way we always have without also

perpetuating the expert-oriented bio-medical model of health, white supremacy and supporting an oppressive system. I believe it is dangerous to assume we are helping promote equity, decolonization, and social justice without taking a hard look at what we are doing and how we are doing it. SCCG is working hard to think about and do things differently.

The World Health Organization (WHO) calls for person-centered and rights-based approaches to community mental health (World Health Organization, 2021a). Around the globe, many people still lack access to quality mental health care including here in Canada. Even with advances in technology and e-mental health options, there are still many rural and remote communities who do not have access due to lack of technology infrastructure. The WHO (2021a) describes the many barriers to equitable mental health care:

> Services face substantial resource restrictions, operate within outdated legal and regulatory frameworks and an entrenched overreliance on the biomedical model in which the predominant focus of care is on diagnosis, medication, and symptom reduction while the full range of social determinants that impact people's mental health are overlooked, all of which hinder progress toward full realization of a human-rights based approach. (p. xvii).

Inequity in mental health care is nothing new (Shim et al., 2018). Mental health services all over the world have continued their struggle to improve accessibility. Socio-economic disparities in mental health care exist in Canada even though we have universal healthcare (Steele et al., 2006). For example, we do not live in a society that offers a person experiencing mental illness access to evidence-based treatment options with the same equitability and ease as someone with a cancer diagnosis. Accessibility is a significant issue that is also present in post-secondary mental health services. Many counselling centres are plagued with long waitlists leaving students waiting for weeks or months to access professional services. Students also face additional barriers that prevent them from seeking professional services in the first place

including stigma and not believing their problem warrants professional service (American College Health Association, 2019).

Post-secondary students have been identified as a unique at-risk group for mental health concerns and have been the focus of many mental health reports, guiding frameworks, and research. For example, Monaghan et al. (2021) identified several student mental health policy documents and reports focused on the provincial, federal, and institutional levels. One example is the new *National Standard for Mental Health and Wellbeing of Post-Secondary Students* which offers institutions a set of comprehensive and flexible guidelines based on best practices to support the mental health and wellbeing of students (Mental Health Commission of Canada & Canadian Standards Association, 2020).

One of the difficult questions I have been grappling with is how to support organizations to engage in radical, system level change in an environment that is risk-averse and resistant to change. I believe the answer lies in engagement at all levels of the organization and multiple approaches to helping. We cannot assume that offering training on recovery-oriented practices to implementation sites will result in the kind of change we are advocating for. We also need a deep understanding of how a paternalistic, oppressive system impacts our implementation work. Having a mental health system that is accessible, empowers help-seekers, is flexible, and context-specific, will positively contribute to equity, ethics, decolonization, and social justice.

SCMs are co-designed by people that are representative of the population the system is serving. In a post-secondary context this would include all members of the university or college community. Including students, faculty, staff, and other stakeholders in the right environment can promote synergy that can lead to innovation and engagement. By exploring different ways of supporting post-secondary institutions implementing recovery principles, we can encourage equalizing power dynamics and synergy through empowering individuals and organizations.

Organizational Change Readiness

In this section, I discuss change readiness within the SCCG organization, as well as change readiness at the post-secondary institutions we are supporting with SCM implementation. Internal and external factors that shape change concludes the discussion in this section.

SCCG's Readiness for Change

Change readiness is infused throughout SCM. One of the SCM guiding principles is there is no ideal solution; trial-and-error leads to growth and change (Cornish et al., 2020). Part of this is achieved through SCM Core Component 4 (Appendix B) which requires continuous service improvement through ongoing cycles of monitoring and assessment. SCCG values applying the SCM principles in our organization, so we are practicing what we preach.

I completed a change readiness questionnaire to assess SCCG's readiness for the changes proposed for this OIP. Cawsey, Deszca, and Ingols (2016) developed this questionnaire that was adapted from several assessment tools found in older literature (Appendix C). The authors' assessment questionnaire includes six domains: previous change experiences, executive support, credible leadership and change champions, openness to change, rewards for change, and measures for change and accountability. The questionnaire measures readiness dimensions with positive or negative numeric scoring. Out of the highest possible score of 35, I rated SCCG at 27 suggesting many positive indicators for change readiness. Some of these dimensions include the direct involvement of trusted senior leadership who are sponsoring the change and view it as necessary, the innovative and collaborative culture that has developed at all levels of the organization, and an environment that rewards taking risk to try new things without fear of negative consequences. As an informal leader at SCCG, I feel comfortable trying new things and taking chances because it is a major part of our organizational culture.

Completing the questionnaire also made me reflect on areas for improvement like internal communication, a common understanding of the proposed change at all levels, and a lack of clear vision of the future related to the proposed change. Many of these areas for improvement are directly linked to the fact that SCCG is a new organization navigating rapid growth and a demanding yet rewarding work environment. With growing numbers and multiple staff working on multiple projects, it can be difficult to keep up with who does what which can lead to unintentional siloing and communication challenges. I will use the Cawsey et al. (2016) questionnaire again along with SCCG's own tools to better understand change readiness over time.

Along with questionnaires, there may be a benefit in observations and interviews to enrich the survey data that we collect. I have been having internal conversations with SCCG staff and leadership. My goal is to better understand how individuals in our organization conceptualize recovery and move us to more of a research-informed, unified definition of recovery-oriented practice in a SCM. I also have conversations with external stakeholders including people with lived and living experience of mental health challenges, peer supporters, families, and community leaders. I find that real-life examples and storytelling enrich and deepen my understanding. I also think it is important to use interviews, focus groups, and informal conversations to assess readiness for change and ongoing improvement as the change happens. This is one of the areas where my authentic and servant leadership approaches are useful. Building trusting relationships, understanding my own values and ethics, having passion for my work, and connecting with people in an authentic and transparent way are all factors that help me assess for change readiness, learn about facilitators and barriers to the change, and plan the implementation process. SCCG appears to have a high level or change readiness based on assessments and collected data, and my experiences of working for the organization for the past two years.

Post-Secondary Readiness Considerations for Change

SCCG has developed its own change readiness assessment tools to help post-secondary institutions measure their organizational readiness for SCM implementation. These tools help us better understand the context, needs, and potential barriers to change that may manifest throughout the implementation process. This assessment includes three sections, general capacity of the organization, innovation-specific capacity for SCM implementation, and motivation for implementing SCM (A. Jones, personal communication, October 15, 2021). Other resources SCCG provides are reflective questions to further assess change readiness, identify key priorities, and offer readiness building strategies.

Factors that Shape Change

Post-secondary institutions face pressures that impact the proposed change. There are internal factors such as reduced budgets for mental health services that conflict with external pressures from students and communities to provide more supports that foster healthy campus communities. Many post-secondary institutions that have implemented SCM have benefited by early success with different parts of the model. For example, SCCG has provided training for campus mental health professionals in single-session therapy which greatly reduces or eliminates waitlists and supports the implementation of e-mental health tools which offer students more self-guided choices to promote mental health and wellbeing. Using the momentum of these early wins may be beneficial to the more complex, longer-term work of implementing recovery-oriented practices at a system level.

SCCG is a rapidly moving work environment. We have multiple small, medium, and large projects at different implementation stages at once. Sometimes this creates priority changes as we do our best to navigate the requests from different organizations, funders, and external stakeholders. As a new organization, we have experienced rapid growth and interest in the work we are doing. Many of us have expressed our organizational context as “building the airplane when it is in the air”. The pace and newness of everything feels exciting, demands the

best of us all, and requires us to create innovative solutions to problems as they come up. I have realized that I need to have a good tolerance for ambiguity working in this context which is easier to do when it feels like we are all united in this together. Having a collaborative and curious environment, I feel safe to take risks and try new things even if they don't work.

Chapter 1: Conclusion

Student mental health concerns will continue to dominate the discourse in post-secondary institutions and communities. Meeting the mental health needs of students is complex and not sufficiently addressed as a supply and demand issue. Recovery-oriented practice emerged as a reaction and alternative to the biomedical model of mental health and shows much promise for transforming mental health care. SCM is grounded in recovery principles which are foundational concepts that are woven into all areas of the model. Given the importance of recovery in SCM, SCCG needs to build training, tools, and an implementation plan to ensure that the post-secondary institutions we are consulting with have sufficient support for the cultural change that is necessary and empower organizations to engage in this journey on their own terms. In chapter 2, I discuss the planning and development of this OIP including a framework for leading the change process.

Chapter 2: Planning and Development

In chapter 2 I discuss my leadership approach to change, a framework for leading the change process, a critical organizational analysis, proposed solutions to address the problem of practice, ethics, equity, and social justice with a focus on reconciliation and decolonization.

Leadership Approaches to Change

My leadership style is grounded in authentic and servant approaches. I am flexible and adaptive, and my approaches evolve as I grow and gain experience. My leadership style is deeply rooted in my personal values of transparency, ethics, caring for others, and contributing to the greater good. These foundational roots will keep me grounded like a tree and my branches will continue to grow and reach new heights with innovative ideas, experiences, and inspiration.

Authentic and servant leadership approaches promote synergy and empowerment as they are relational, focus on meaningful environments for change, and are ethical in nature (Duignan, 2014; van Dierendonck & Sousa, 2016). My leadership approach focuses on relationships and relies on compassion and attunement to others. I believe that we are better together. I aim to unite organizations with vision, meaning, and purpose with authenticity and transparency. I will draw from Stakeholder theory to inform the synergistic and relational aspects of the proposed change implementation plan. Stakeholder theory was introduced in the 1980s by Edward Freedman and can be defined as a focus on internal and external stakeholders working synergistically to create value in an organization (Freeman et al., 2018; Phillips et al., 2019). Stakeholder theory has been studied in both health (Kok et al., 2015) and higher education contexts (Langrafe et al., 2020). I intend to draw from this theory to inform the relational process skills from my authentic and servant leadership approaches that are key to building buy-in and setting a strong foundation for the proposed change.

Rather than viewing leadership as one fixed, predictable approach, I prefer to recognize the combination of these approaches that are connected to who I am as a person and my

values. Leadership approaches are also context specific as I navigate different goals in my work environment. I believe it is important to recognize that leadership is a construct that varies over time. For example, I may have intrinsic qualities and values as a leader, but I also interact with my colleagues, environment, workplace roles and expectations which are all in a state of flux. Our realities are co-created. Liao et. al (2020) add that daily servant leadership behaviours can take a toll, so I must continuously work on balancing and replenishing my mental and emotional energy. I can also see potential challenges for authentic leadership approaches. While I strive for relational transparency, the reality is that I cannot always share full and complete information with those I lead. Sometimes this comes from ethical approaches that require extra discretion or workplace policies regarding information sharing. I usually find my emotional and mental energy replenishing itself with a deep sense of meaning, purpose, and engagement in my work. I would not be speaking authentically if I did not admit that there are days when I have less emotional and mental energy which can negatively impact my servant leadership behaviours.

Just as I will continue to learn and grow as a person and professional, I expect my leadership approach to grow with me. Along the same vein, many leaders or managers view problems as something concrete that they can measure and solve in a linear manner. The reality is that “complex problems require managers to cope with dilemmas in the system rather than to arrive at definitive solutions” (Higgs & Rowland, 2007, p. 123). It is wise to keep this truth in mind, especially given the complexities of my workplace, and the post-secondary institutions in which I am supporting SCM implementation.

Leadership and Recovery

Authenticity, respect, and humility are core values of my leadership approach and are well aligned with recovery principles. I work from a non-expert stance and focus more on building relationships, community, and synergy with the goal of empowering us all to work toward the greater good. While there are many descriptions of recovery principles in the literature, the Substance Use and Mental Health Services Administration (SAMSHA) (2010)

offers 10 recovery principles that underpin my leadership approach. These principles were co-developed with a diverse group of stakeholders including persons with lived and living experience of recovery. Each recovery principle is unique and valuable. They are not typically conceptualized in a hierarchy. Below I will list the SAMSHA recovery principles with brief commentary on how they influence my leadership approach and work in SCCG:

1. Recovery emerges from hope.
2. Recovery is person-driven.
3. Recovery occurs via many pathways.
4. Recovery is holistic.
5. Recovery is supported by peers and allies.
6. Recovery is supported through relational and social networks.
7. Recovery is culturally based and influenced.
8. Recovery is supported by addressing trauma.
9. Recovery involves individual, family, and community strengths and responsibility.
10. Recovery is based on respect.

Recovery is based on respect and hope and is person driven. An SCM that is infused with recovery respects the dignity and rights of all people, especially persons seeking help. Hopefulness drives the care system. Recovery is not only hoped for but expected. Recovery is about a shift in power from clinicians, administration, and policy makers to the people receiving services and supports. This person-driven principle aligns well with my non-expert stance in my leadership framework. As an authentic and servant leader, I assume the role of guide or facilitator of process. My leadership focus is on the empowerment and growth of people seeking help, and creating an environment where people get the care they need when they need it.

Recovery being a highly complex and personal process means that help-seekers need to have choices to engage in the right supports at the right times. Having choices and making informed decisions about one’s own care is a foundational concept of SCM (Cornish, 2020).

Like recovery, holistic health is a concept that is a response to the biomedical model of health care that considers sociocultural and systemic factors (Zakkar et al., 2021). Instead of viewing students through the lens of pathology, a holistic health perspective considers the whole person which can include mental, physical, spiritual, social, and emotional health (Horgan et al., 2021). I rely heavily on relationships, transparency, and trust to work from a holistic perspective.

Recovery is supported by peers and allies, and through relational and social networks. Recovery does not exist in a vacuum. Peers, allies, and inclusive communities are powerful strengths that help individuals on their recovery pathways (Repper et al., 2013; Saheb et al., 2019). Recovery is impacted by individual, social, and community aspects. Recovery is culturally based and influenced. As an authentic leader, I draw from my own experiences to inform my actions while as a servant leader, I am focused more on the experiences of those I work with. I strive to hold dual awareness, holding these internal and external experiences at the same time. While all SCMs are aligned with the same principles, they look different in every community and are co-designed by the people living and working there. For instance, a SCM at a small, rural university campus would likely look different than at a large urban community college depending on factors such as resources available and accessibility. This flexibility allows for the local culture and self-identified needs to be highlighted.

Recovery involves individual, family, and community strengths and responsibility. This directly aligns with SCM's third principle: "all individuals and communities have strength and capacity" (Cornish, 2020). We all have a part to play and responsibility to hold in our communities. Stigma is still a significant problem that isolates and shames people experiencing mental health difficulties which can negatively impact help-seeking behaviours (Sickel et al., 2019). It is also a problem in post-secondary communities (Gulliver et al., 2019). This can create isolating experiences for individuals and perpetuate discrimination of persons experiencing poor mental health. This can result in pushing them to the edges of our society. Recovery definitions highlight the strengths that come from having interactions with peers, family support, and

inclusive communities (Mental Health Commission of Canada, 2021b; Substance Use and Mental Health Services Administration, 2010).

Recovery is supported by addressing trauma. Trauma-informed practices began in the field of medicine in the 1970s and have gained traction spanning many professions including psychology, psychiatry, and education (Berger & Martin, 2021). Trauma-informed care can be conceptualized "as the knowledge, recognition, respect, and concern to care for victims who have experienced physical or emotional trauma" (Guest, 2021, p. 1006). Trauma-informed frameworks "recognize the high prevalence of prior trauma for people who experience mental health problems and the profound impact of trauma in one's life" (Watson et al., 2014, p. 535). Although there are many definitions and applications of trauma-informed practices, these approaches are not explicitly included in all recovery definitions which is why I find the SAMSHA principles so relevant and useful. Addressing trauma is critical in every recovery process. For instance, it is not helpful or holistic to focus solely on a person's symptoms of mental illness or substance use without respecting the broader context of their life experiences, the effects of intergenerational trauma, or other considerations outside the bio-medical model.

The famous Center for Disease Control-Kaiser ACE study published in 1998 propelled our understanding of how adverse childhood experiences (ACE) impact people in adulthood and has important implications for leaders in mental healthy. ACE can be defined as psychosocial factors that have a significant negative impact on a person's health (Felitti et al., 1998). Many ACEs are traumatic in nature including things like child abuse and neglect. Since its publication, the literature on ACE and implications for adult health has grown significantly with findings indicating a positive correlation between ACE and most major causes of death in adults in the United States (Petruccelli et al., 2019), and higher rates of mental illness and substance use disorders in young adults (Moss et al., 2020). Lastly, it is particularly important to address the intergenerational trauma present in Black, Indigenous, and persons of colour (BIPOC) communities that continue to face racism and oppression. This is important because if we

maintain the status quo, those of us with privilege and power will continue to ignore the systemic oppression and social determinants of health that are very real for many of these communities. This topic will be explored in more detail in subsequent sections of this chapter.

I believe servant and authentic leadership approaches complement each other in a way that fits well with my personality, worldview, work context and priorities. For example, I hold the belief that every person has strength and capacity to determine and take the lead on their own recovery journey. These beliefs directly impact how I work and what I produce. These leadership approaches keep me grounded in a fast-paced work environment with many deadlines and changing priorities. Deadlines are important but slowing down enough for deep reflection and relationship building are equally valuable. I believe that this is the kind of workspace that fosters creativity and innovation. Servant leadership is particularly well suited to trauma-informed mental health work as it promotes safety in relationships and can help in the healing process. For example, Spears (2010) states:

> Many people have broken spirits and have suffered from a variety of emotional hurts. Although this is a part of being human, servant leaders recognize that they have an opportunity to help make whole those with whom they come in contact. (p. 27)

While I don't feel solely responsible for making others whole, I work to create respectful, safe, spaces for our collective healing. I am drawn to the Spears (2010) definition because it speaks to me personally, and I see it in the reality of my everyday work context.

Authentic and Servant leadership approaches aligns well with recovery and synergy. The concept of synergy has many conceptualizations and is often discussed in the SCCG workplace. This concept is woven throughout the SCM framework. SCCG's latest conceptualization of synergy is "a strategy focused on building organizational interdependence can better serve to remove the stigma attached to labels, ensure individual agency and empowerment, and address the negative impact of historically oppressive mental health practices" (G. Berry, personal communication, Nov 28, 2021). The eighth SCM guiding principle

states that “the whole is greater than the sum of the parts: the strength of the system relies on multilevel collaboration” (Carey et al., 2021, p. 7). I experience synergy as people in energetic, creative flow, working together to create something larger than themselves. Peer support is a great example of recovery principles in action and can create synergistic communities that foster empowerment on an individual and group level. In peer relationships, power is shared equitably, what is good for one person is good for everyone in the community, and the whole community is greater than the sum of its parts (Katz et al., 2012)

Framework for Leading the Change Process

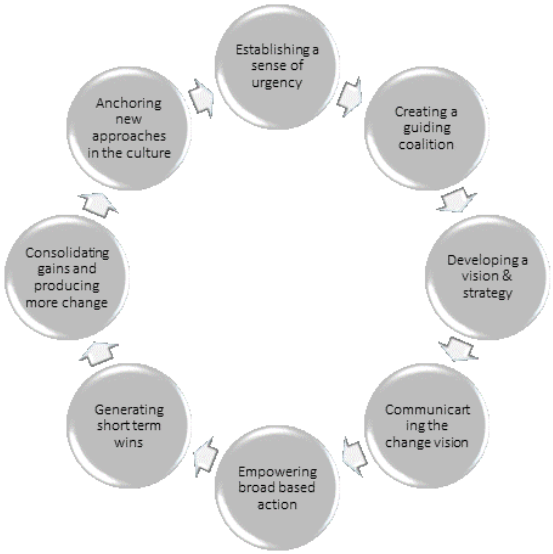
I will be drawing from two change path models to address my problem of practice. First, I will use Kotter’s eight-stage change path model to guide the overall change process (Kotter, 2012; Kotter & Schlesinger, 1979). Kotter’s stages (Figure 3) are: establishing a sense of urgency, creating a guiding coalition, developing a vision and strategy, communicating the change vision, empowering broad-based action, generating short term wins, consolidating gains and producing more change, and anchoring new approaches in the culture (Kotter, 2012). Second, I will use a plan-do-study-act (PDSA) cycle (Deming, 2000) to evaluate milestones throughout Kotter’s model. Both models are widely used in health care (Taylor et al., 2014) and higher education institutions (Wentworth et al., 2018). My rationale for combining these models is to offer ongoing evaluation throughout the broader change process to build momentum, buy-in, and offer data to people who may be skeptical to this kind of change. I have found that there can be a lot of skepticism and anxiety when the risk paradigm is being challenged and the PDSA cycle will offer short-term evaluations to help with this. For example, Kotter’s stage 6, generating short term wins, can keep the momentum for change going. Adding an evaluation process through a PDSA cycle will offer more detailed information about the change to celebrate the wins, and to fail forward when things don’t work out as planned.

Kotter's Model

John Kotter outlined eight stages organizations can use as a change path model (Kotter, 2012). It has grown in popularity since Kotter's seminal work in his book *Leading Change* (1996) and has been applied successfully in multiple settings including in health care (Weiss & Li, 2020), higher education (Wentworth et al., 2018), and other diverse organizational settings (Pollack & Pollack, 2014).

Figure 4

Kotter's Change Model



Kotter's model has been criticized in the literature for being too linear and rigid, as well as not having enough varied research to support it. For example, Applebaum et al. (2012) question the validity of Kotter's model as it was originally based on Kotter's own experience and research while failing to include outside sources. Even with these limitations, Kotter's model continues to be useful to many organizations and it is apparent that many change leaders are adapting it or complimenting it with other change path models (Appelbaum et al., 2012; Campbell, 2020). Kotter himself later wrote that the model is more flexible than it may appear, claiming that one stage leads to another, and that it is common to go back and repeat stages when necessary. This is also a common misconception of the SCM. The SCM steps are listed in

a linear visual (Appendix A), but we have found it is common for help-seekers to have several access points to choose from and to be engaged in multiple steps at one time. A non-linear example of a SCM is presented in Appendix A.

Plan Do Study Act (PDSA)

Plan, do, study, act (PDSA) cycles are also common change frameworks in organizations including health care. The PDSA cycle was originally developed by Edward Deming (Deming, 2000; Donnelly & Kirk, 2015). The “planning” stage is when objectives based on the organization’s needs as well as the people they serve are set. The “do” stage is when testing the change that was identified in the planning stage occurs. The “study” stage is the part of the cycle when the analysis of the test results takes place. Finally, the “act” stage is when the integration of any changes for improvement based on the analyzed results of the previous step occurs(Donnelly & Kirk, 2015).

The Canadian Patient Safety Institute and the *SCM Implementation Guide* both recommend using PDSA cycles for implementing change (Canadian Patient Safety Institute, 2015; Carey et al., 2021). While PDSA cycles are popular in the change management and quality assurance literature, their application can vary widely, especially in complex systems (Taylor et al., 2014). While some may believe this to be a limitation, there is value in any model that offers flexibility so that it can be adapted to the context in which the change is happening and can help us pivot when unexpected barriers arise.

Kotter With PDSA Cycles

To address this PoP, I propose using PDSA cycles embedded throughout Kotter’s (2012) 8 stages to measure and evaluate the change process. My rationale for this is by sharing overall successes like short-term wins can keep the momentum going and having data from short evaluation cycles can support this objective. Also, a PDSA cycle throughout the stages Kotter’s (2012) model can offer an evaluation of progress which could be helpful to address critics or other barriers to the change process. For example, creating buy-in for the change is

important early in Kotter's (2012) model, and evaluation data from PDSA cycles could make a positive contribution. This also aligns well with the SCM principle of continuous monitoring and improvement cycles.

There are examples in the literature of Kotter's (2012) model being integrated with other frameworks in a complimentary way that supports the change process. For example, Bradbury (2014) discusses using Kotter's model in combination with complex adaptive systems and learning communities as a framework for change. In contrast to some of the criticisms of Kotter's model, Bradbury (2014) states that "whilst often seen as linear, Kotter's model has allowed cyclical, double loop learning and an intensive focus on refining the vision and guiding coalition within local economies" (p. 138). Double loop learning is highly relevant in educational leadership, recovery, and systems change because it promotes innovation, questioning of underlying assumptions and core beliefs that can lead to deep reflection, culture and perspective changing (Cartwright, 2002). The paradigm shift of SCM and recovery is significant and requires this kind of deep learning, questioning, and reflecting. Having a change path model that allows for this kind of learning is important in order for true and meaningful change to occur.

The limitations of the PDSA cycle can be complimented by Kotter's (2012) model and vice versa. For example, Etchells et al. (2016) state that a common misconception of PDSA cycles is that they are simple and easy to use by anyone in any context. The authors caution us on using PDSA as a stand-alone method of testing change. Instead, they claim that PDSA is a useful tool when combined with other complimentary change management and quality assurance methods. Kotter's model offers an overarching framework to guide the larger change process, while the PDSA cycles embedded throughout can help in evaluating and improving the change throughout the process.

Critical Organizational Analysis

In this section, I offer a critical analysis of SCCG building on the content of the previous chapter, and the change path models of the previous section. In an effort to practice what I

preach; I have aligned with SCM values in my analysis. I am writing this from a frame of strengths and opportunities rather than deficits while also considering challenges and how we might navigate them. Based on the Cawsey et al. (2016) change-readiness assessment questionnaire discussed in chapter 1, I gave SCCG a high score indicating positive readiness for change based on factors such as the direct involvement of trusted senior leadership who are sponsoring the change and view it as necessary, the innovative and collaborative culture that has developed at all levels of the organization, and an environment that rewards taking risk to try new things without fear of negative consequences (Cawsey et al., 2016). These are generalized factors and there are more specific and contextual factors to consider. These factors will be discussed in the remainder of this section.

SCCG has been experiencing exciting and rapid growth over the past two years. This growth includes a significant increase in contracts, interest in research and development, and an increasing number of staff to manage the workload. During this time, we have received increasing interest in the SCM and implementations in post-secondary institutions and provincial and federal governments. This has partially been due to the increased attention to the need for e-mental health tools and virtual options for clients in the wake of the COVID-19 pandemic and the continued focus on student mental health programming, needs and services.

SCCG has significantly invested in developing e-learning modules and implementation tools over the past two years. This includes introductory courses about SCM and its various components. SCCG is at the beginning stage of developing a digital library of courses and resources that can be accessed by our clients to support their SCM implementation efforts. Because there are still so many courses to develop, SCCG has had to prioritize and re-prioritize the order of development to meet the evolving needs of our clients who are implementing SCMs.

Working in a fast-paced environment with priorities that can change daily is both exhilarating and challenging. In my role this usually means continuously re-prioritizing work

objectives which is likely to impact some of the visioning and development work that takes more time and focus. The expectations of our funders do not always line up with our priorities even if we have the same overall goal. While we provide expertise on how to get to that goal, the reality is that our funders have significant influence on what we do and how we do it. For example, some funding sources have strict parameters in how and when the funds are used, or a short turnaround time for a project to be complete. This is a tension most of us in SCCG continue to navigate as we do our work.

One gap that I have noticed is that SCCG does not have a formalized, dedicated team to support post-secondary implementation projects even though we have several small, medium, and large institutions we work with. A team could bring cohesion to the great pieces of work that are happening in isolation. Pockets of people in our organization have worked on specific things such as SCM implementation at one institution, or the development of research-informed documents and knowledge translation tools that connect SCM principles to the new *National Standard for Mental Health and Wellbeing of Post-Secondary Students* (Mental Health Commission of Canada & Canadian Standards Association, 2020). Working in silos could lead to fragmented or duplicated efforts for different post-secondary implementation projects and a disconnect between the talented and experienced staff members working on different pieces of different projects.

There are factors that are out of SCCG's control such as newly elected governments with their own priorities that may or may not include our work, and operating within someone else's timeline, such as that of funders, government agencies, or academic institutions. For example, it is common for post-secondary implementers to require certain training at certain times in preparation for their SCM launch, which is often held at the beginning of the fall semester and academic year. Another factor out of our control is that we work in an exclusively digital environment. Even though a small number of us have worked in person together in the past, most of our team is working from different communities across Canada and the United

States. SCCG along with the rest of the world had to quickly pivot to working in a 100% digital environment while at the same time growing with new contracts and new employees with different roles, expertise, and skills.

Working remotely provides significant opportunities. For example, I can work with a diverse group of colleagues living in different communities with different expertise and experiences. This would be more difficult or not possible if I worked in person at an office. I am constantly exposed to new and interesting people with whom I can work collaboratively which is exciting and from which I gain a lot of valuable experience and learning. Organizational socialization and organizational culture are complex in a virtual work environment (Asatiani et al., 2020). I think this is particularly challenging for new organizations experiencing rapid growth like SCCG. This is an area where I plan to use the relational aspects of my leadership approach. While it is difficult online, building trusting and authentic connections with my colleagues and other stakeholders is critical to my success. For example, I use tools like video conversations to get to know my colleagues including what they are passionate about in their work. It will be important for SCCG to learn and reflect upon the advantages and challenges of working in a digital environment especially because we will continue working in this context even after other organizations have returned to in-person workplaces.

One interesting thing I have noticed about SCCG's organizational culture is that while it is collaborative, it is also individualistic in nature. Individualistic cultures tend to value autonomy and self-determination, while collectivist cultures value group interdependence and group goals over individual (Triandis & Gelfand, 2012). While aspects of both can exist together, it is important to explore them in context to ensure that they are not in conflict. For example, SCCG values individuality, autonomy, and self-determination but also recognizes that we are interdependent and need each other to move work forward. Synergy is valued but there are challenges to apply it in practice, especially online. Collectivist practices are particularly complex in a virtual environment where collaboration looks different than what most of us are used to,

and experiences of isolation are a challenge (Vallo-Hult & Byström, 2021). I think it has been more difficult to connect, communicate, and get know each other well enough to collaborate as well as we could in person. Considerations of these factors could ensure that SCCG can work effectively and optimally while staying grounded in its core value of synergy.

SCCG uses change readiness assessments with sites, including post-secondary mental health services, who are at the beginning of their SCM implementation. This helps us understand our client's context-specific needs and tailor our resources and consultation to meet them. I thought it would be useful to apply the relevant sections from our assessments internally to determine our own change readiness related to recovery visioning as a part of my critical organizational analysis. This is a different change readiness tool to use in addition to the Cawsey, Deszca and Ingols (2016) tool discussed in chapter 1. Using multiple and diverse assessment tools is a good way to promote the triangulation of data. I am working under the assumption that since SCCG values continuous improvement and put the time in to developing this questionnaire for clients, they would be interested in applying some of these questions to themselves. I chose to explore *Part 1: General capacity for your organization* which has 27 items rated using a Likert scale. Table 1 shows a six-item sample from my assessment of SCCG.

Table 1

SCCG Change Readiness Assessment Example

Statement	**Strongly Disagree**	**Disagree**	**Slightly Disagree**	**Neither agree nor disagree**	**Slightly agree**	**Agree**	**Strongly agree**	**Don't know**
1) Leadership at our organization listens to different perspectives							X	
2) Our organization has a common purpose							X	

Statement	**Strongly Disagree**	**Disagree**	**Slightly Disagree**	**Neither agree nor disagree**	**Slightly agree**	**Agree**	**Strongly agree**	**Don't know**
3) Leadership at our organization rewards creativity and innovation							X	
4) We work well in a collaborative way across teams		X[1]						
5) We know our organization's vision					X[2]			
6) The way we are structured makes it possible to do things well				X				

Note. [1] We are a collaborative staff but there is little organization or intentionality to the actual process. We are sometimes siloed in our project teams out of necessity.

[2] We have a good sense of common purpose but because we are still new our organization has been co-designing an actual vision for our work. We have made some progress, but we are in early days as an organization.

The *general capacity for our organization* section of the assessment includes a wide array of measures exploring organizational environment, culture, and leadership. Overall, I rated SCCG highly in terms of capacity, and I found some areas that could use improvement. For example, SCCG has strong leadership that is open to diverse perspectives, works from a learning mindset, rewards innovation, celebrates team success, and has alignment with our core values. Visioning, on the other hand, it still very much in progress. SCCG has made good efforts in this area by hiring an external contractor to work with us on developing a strategic plan for the next five years. Because SCCG has taken on so much work resulting in rapid growth, its sense of vision has not always been clear throughout the organization, particularly with newer

employees. Currently, SCCG's vision is grounded in the idea of bold mental health system transformation. We are still in the early stages of unpacking what we mean by this while at the same time developing an organizational identity.

Another area for improvement I identified with this assessment is related to SCCG's operations. There are challenges in our collaborative work across teams. Communication and collaborative work are difficult in a virtual workplace especially when we are using different tools. For example, we are all working on different tasks using whatever software we choose. This has resulted in some difficulties organizing material, avoiding duplicated work, and collaborative processes. SCCG's most significant challenge is time. The visioning and internal work I am suggesting takes time, thoughtfulness, and deep reflection individually and collectively. We must slow down or pause to engage in this work. This is a barrier I will continue to face, and I will have to think of creative ways to engage our team throughout the process. It is possible that the shorter PDSA cycles will be useful to show the short-term wins, make adjustments, and continue forward with momentum.

Lastly, on an individual level I have noticed challenges internally as I engage in recovery work on a systems level while simultaneously identifying as a person experiencing recovery. This regularly creates barriers for me and if I don't pay attention to them, my work will be impeded, and my health compromised. For example, I need to be careful to avoid focusing too much on my own experience and context so that I can consider other perspectives, ways of healing, and conceptualizations of recovery. I have also noticed that when I suggest or ask for something specific that I need to use in my recovery work at SCCG, it can feel personal if I am met with questions or perceived dismissal. Even though I logically understand reasonable questions or challenges, sometimes I feel "othered" based on my past negative experiences of being treated differently as a person with a clinical diagnosis. I feel immense pressure to get things right and a fear of failing or causing further harm to my own community. To navigate these challenges, I continue to look for productive ways to understand and express my

experiences, while engaging in good self-care. Connecting with peers in other organizations also helps. These are considerations I will keep in mind as I explore possible solutions to address my PoP.

Solutions to Address the Problem of Practice

There are often multiple pathways forward to address challenges. In this section, I will explore the following four possible solutions to address the identified problem of practice: maintaining the status quo; continued training and resource development work; doing our own internal recovery work; and building on research and visioning. I will evaluate each possible solution by considering viability, reasonable timelines, and resource expectations, whether they are in my scope of practice or agency to lead, and if they will comprehensively address my PoP in a way that is aligned with my leadership approach and core values.

Solution 1: Maintaining the Status Quo

Maintaining the status quo goes directly against SCCG's vision of bold mental health system transformation. We continuously challenge the status quo externally while at the same time, we are working to challenge it internally. Continuing our current trajectory, that the status quo of SCCG will likely be to continue to develop training and resources related to recovery, and that my role would be responding to the needs of our clients. I have noticed a tendency to focus on clinical services first which can include counselling, crisis management, psychiatry, and primary care services among others. This appears to be the current status quo in SCCG's work with post-secondary institutions. If this path continues, I will likely continue educating SCM implementers about recovery if they ask for it, and SCMs would continue to focus on clinical service priorities such as reducing waitlists. While it would not likely do any harm, maintaining the status quo doesn't exactly inspire innovation. The status quo is a reactive approach focused on client requests which are important to consider when operating a business. At the same time, maintaining the status quo would not allow us to diplomatically disrupt ourselves or our clients and support new ways of organizing mental health services, thinking, and being.

Maintaining the status quo in the post-secondary health and wellness environments is a part of why there are struggles with the perceived student mental health crisis. It is well documented that there is an increasing demand for student mental health supports (American College Health Association, 2019), and students are more vocal about mental health issues than past generations (Michaels et al., 2015). Maintaining the status quo in a post-secondary mental health context has often looked like a perceived crisis, resulting in mental health administrators advocating to hire more professionals (Xiao et al., 2017), even though these interventions can have limited impact on service wait lists (Cornish et al., 2017). There are usually other student wellness supports on campuses such as peer support, special interest groups, and student unions to name a few. Many of these supports are fragmented from professional services or each other, even though they might be excellent resources. In addition, students may not know about them, they may be hard to find, or they may not be organized in a way that is accessible and easy to navigate.

It is difficult to jump right to implementation of programming and training without some of the culture-changing efforts that drive the SCM such as recovery-oriented practice and co-design. In my own experience, I found it difficult to focus on creating training for campus peer support programs if it was within a system that had not adopted recovery principles. This bothered me enough that I changed my job role and position within SCCG to specifically address this necessary re-ordering of priorities and was fully supported by leadership. There are benefits to focusing on the clinical elements of the SCM. This can lead to short term wins that can fuel momentum for the longer-term change. For example, training counselling staff in single-session therapy has led to increased access and the reduction or elimination of waitlists (Cornish et al., 2020; Mental Health Commission of Canada, 2019). Post-secondary institutions face immense public pressure to deliver services that lead to better mental health outcomes for students (Brown, 2018). This pressure and the complexity of funding allocation can lead to tight

timelines that SCCG needs to work within. These are changes that deliver short term wins and challenge the status quo without abandoning their already existing healthcare system.

Solution 2: Continue Training and Resource Development

SCCG has invested a lot of time and resources into developing training and knowledge translation products for our clients. One option to address my problem of practice is to continue supporting training and resource development and ensure that they are recovery oriented. The development of recovery training for SCM implementers is a SCCG priority that is my responsibility to lead. These tasks are challenging as there are many definitions of recovery, diverse implementation sites, and there have been few publications connecting recovery to the SCM. At this point, SCCG's general message clearly states that recovery principles are woven throughout every SCM with a basic conceptualization of what that means. SCCG recognizes the need for development in recovery in SCM for our different implementers including our post-secondary clients.

Training for SCCG began as presentations and consultations on a small scale with a small number of mental health leaders and experts. Recently, SCCG has obtained its own learning management software where it is possible to develop and host asynchronous training modules, resources, and supplemental materials, and engage in other learning activities such as hosting communities of practice. SCCG also has a blog and a new podcast to promote discussions, our current work, and to bring together others working in the mental health field.

The problem with choosing this option is that I don't think that training alone is sufficient to address this problem of practice. Training and resource development play an important role in the recovery strategic visioning and planning process, but the deeper process of visioning and planning will take more time which is a real challenge in our demanding work environment. Still, I believe that making time is important if we are going to hold ourselves to the same principles as our clients. I also think that there are opportunities to include more diverse ways of knowing and learning in our training development and delivery. If we stick to the status quo of e-learning

modules and formal presentations, we are missing out and could be perpetuating oppression by favoring a western, Eurocentric way of learning.

If we truly want to engage with diverse communities, it would be helpful to listen and learn from them and consider different ways of doing things that might be outside our comfort zone. On the other hand, most post-secondary institutional clients have a system and culture that is used to the more westernized ways of learning and being. One of the struggles I have observed is the friction between the individualistic nature of the biomedical model in mental health and the collectivist nature of SCMs and recovery in general, particularly when challenging the risk paradigm. SCMs grounded in recovery require a transfer of power and responsibility for managing risk to a collective group of people including persons seeking help, their families, communities, and various mental health professionals. Training alone cannot address this deeper, cultural friction that comes from moving away from the biomedical model to recovery-oriented practice and challenging the risk paradigm. Mental health professionals are trained to be experts and to hold responsibility for their clients' safety which is regulated through professional standards of practice and codes of ethics. While mental health professionals have an important role to play in any health system, we need to move away from considering them as the default choice, the only option, or the gold standard of care.

Solution 3: Internal Recovery Work and Recovery-Oriented Workplace

If SCCG wants to apply the SCM principles internally as an organization, then we must be doing the deeper work to do so. This is important for our organizational, experiential learning, and for maintaining credibility. Just as we need more than simply training or cognitive understanding of these principles to shift our orientation toward recovery for our clients, we need to be doing the same work ourselves. This is a real challenge in practice as SCCG continues to grow, manage several large projects, and work at a fast pace, juggling multiple deadlines. There are also difficulties building deeper relationships with other staff in a digital environment. Creating safety and trust in a virtual workplace is complicated especially when it is

challenging to find the time. However, having safe and trusting connections with each other is vital to creating an environment where we can reflect, show vulnerability, ask difficult questions, or challenge long-held assumptions and beliefs.

While I believe and advocate for this reflective, exploratory work, I do not think it is reasonable to expect that this approach alone will be practical and sufficient in the SCCG work context. I show initiative and leadership in this area and can often be found writing reflective notes or commentaries that are authentic and embrace all parts of my identity. I sometimes choose to share my words with others in my organization with the goal of creating safety through vulnerability. It is my hope that leading by example will encourage others to consider different perspectives, and to allow their own experiences to inform their work even if they choose not to disclose anything. There are many ways to use our intersecting identities and life experiences to inform our work.

This possible solution to my problem of practice feels like a dream that is just out of reach. While I can make impacts in small ways, any major changes in SCCG's culture around recovery would have to be encouraged and led by senior leadership and bought into effect by others in the organization. SCCG values recovery and encourages me to do this work; however, we have less experience operating as a larger organization and applying recovery principles to ourselves and those around us. I will continue to support our internal growth in this area but will not choose this solution because it does not seem like a realistic goal in addressing this problem of practice. It also seems a little outside my scope of influence and agency.

Solution 4: Build on Research and Visioning (Recovery and SCM)

SCCG can contribute to the recovery literature as there is limited research on recovery in SCMs. Recovery is such a broad concept that it can be challenging to know where to start and how to apply it in practice. For example, the practical application issue was part of the rationale for the MHCC's recent publication of an implementation toolkit for recovery-oriented practice (Mental Health Commission of Canada, 2021a). The MHCC published guidelines for

recovery-oriented practice in 2015 which have been widely accepted and celebrated in Canada; however they quickly noticed a gap in their actual implementation (Mental Health Commission of Canada, 2015).

To address the need for evidence and implementation guidance, part of my role at SCCG has been supporting rapid reviews of the SCM core components. These reviews can be defined as “a form of knowledge synthesis that accelerates the process of conducting a traditional systematic review through streamlining or omitting a variety of methods to produce evidence in a resource-efficient manner” (Hamel et al., 2021, p. 80). The purpose of these reviews is to gather current, relevant literature and connect it to SCM principles. SCCG is often asked for empirical evidence to support client and system outcomes, and this information is helpful to have when creating buy-in particularly with skeptical leaders, administrators, and mental health professionals. SCCG is in the beginning stages of planning a rapid review for SCM core component 5: “Recovery-oriented practice is demonstrated clearly and consistently” (Cornish, 2020). This review could help define recovery in SCMs, identify gaps for future research, create buy-in among clients and stakeholders, and contribute to establishing a sense of urgency which is the first stage of Kotter’s (2012) model. Establishing a sense of urgency is important to ensure that recovery work in SCMs gets the focus that it needs. Many leaders within SCCG and post-secondary mental health have an academic background and this kind of evidence is important to show in order to validate our work.

If we are to honour diverse ways of knowing and understanding the world, we need to begin decolonizing research. Randomized controlled trials (RCT) are an example of a euro-centric, westernized approach to research that is widely accepted as the gold standard in academia (Hariton & Locascio, 2018). Things like recovery, co-design and peer support are all examples of things that are difficult to measure with a quantitative RCT, especially with the focus on generalizing a population, and with the high variability of recovery definitions in the literature (Slade & Longden, 2015). Goldsmith et al. (2019) found that using co-design in RCTs

can enhance social accountability, promote diverse voices including people with lived experience, and provide rich data if it is done in an authentic and meaningful way.

Eurocentric approaches to research tend to be individualistic and seek to understand things that can be quantified. The more I dig into the recovery work, the more I realize that I am seeking knowledge in relation rather than individualized, quantified data: I want to understand how things are happening in relation to one another. Even the concept of recovery in the western world has aspects of individualism. Most definitions include statements that recovery is a personal, unique process or a process that promotes autonomy. Many conceptualizations of recovery also include the importance of supporting communities, and the value of peer supporters in a person's recovery journey. Recovery has an important role to play in decolonizing research and there is much opportunity to explore it with diverse ways of knowing and seeing.

Identifying a Preferred Solution

In Table 2, I considered the identified possible solutions for their viability, resource needs, whether they are in my scope of influence, and if they align with my leadership approach and core values.

Table 2

Evaluating Possible Solutions

Possible solutions	Viability	Resource expectations	Agency/scope of influence	Alignment with values/leadership approach
Maintaining the status quo	Easy to do	Same as they are currently	Not in my scope of influence	No
Continuing training development	Ongoing and likely to continue	Significant resources already being invested here	In my scope of influence	Yes

Possible solutions	Viability	Resource expectations	Agency/scope of influence	Alignment with values/leadership approach
Internal SCCG recovery work	Not viable for one cycle of change	More time and human resources needed	I contribute here but it a piece of the larger synergy team's work	Yes
Build on research and visioning	SCCG in beginning stage with rapid reviews	More time and human resources needed	In my scope of influence	Yes

Out of the previous discussion of possible solutions to address this problem of practice, I have chosen to combine two. Building on research and visioning combined with continued training and resource development can compliment each other. A focus on vision and contributing to research on recovery in the SCM will help with the bigger-picture conceptualization that needs to happen while still allowing me to stay in my own agency lane. Training and resource development will continue to be a priority for SCCG and play an important role in how we present recovery in the SCM and support its implementation. Visioning and deepening recovery concepts and research will inform the training development and vice versa. It is also a practical reality of my role in the organization and the tasks I am responsible for.

Ethics, Equity, Social Justice, and Decolonization Challenges in Organizational Change

"Nothing about us without us" is a phrase that was popularized by the global disability rights movement of the 1990s even though it has been used throughout human history (Charlton, 1998). This slogan implies that no policy should be created or decided on without representation of the people who will be directly affected by it. It is widely used and celebrated in the consumer/survivor and lived experience communities. I view it as the tagline of recovery. It represents the shift in power dynamics where people experiencing mental health challenges

advocate to be included in their own care, in system redesign work, and in the larger community. SCMs embrace recovery and inclusiveness. For example, co-designing a SCM in a community requires representation from all key stakeholder groups including people with lived and living experience. These groups work together, sharing power and decision making, to design their own SCM.

Ethics, equity, decolonization, and social justice are constructs that are embedded in all areas of this OIP, throughout recovery, and in the SCM. Recovery is all about equity and power sharing. The principles of the SCM (Appendix A) are infused with recovery principles that promote ethics, equity, and social justice. For example, the first SCM principle is: *Social justice drives effective care system transformation and is an intervention in itself*. Other principles highlight the importance of recovery-oriented practice, the belief that individuals and communities have strength, and the provision of choices for persons seeking help. These values and principles are aligned with the *Accessible Canada Act* which was enacted by the Government of Canada with the purpose of ensuring that all people, including persons with disabilities, can achieve full and equal participation in society (Government of Canada, 2019).

SCCG has been intentionally engaging in discussions attempting to deconstruct terms such as diversity, equity, and inclusion. We recognize the importance of these terms but also do not want to engage in surface-level acknowledgment statements that result in tokenism. Rather than separating diversity, equity, and inclusion into a separate box on its own, SCCG has been drawn to the word synergy. Many post-secondary students in Canada struggle with mental health problems and accessing the care they need (Canadian Alliance of Student Associations, 2018). This fact is one of the driving forces behind the SCM which promotes open access to a variety of options that person seeking help can choose from at the time they are in need.

Systemic Barriers and Stigma in Mental Health

Empowerment of help-seekers is more complex than one may realize. Internalized stigma and internalized colonialism have disempowered individuals and communities for

decades. The biomedical model of health is paternalistic in nature and perpetuates internalized stigma by pathologizing human experience. For example, if a person is being treated for a mental illness, they will likely be assessed based on behavioural symptoms and medicated to help them function in society according to dominant norms. If a person is repeatedly told the narrative that they are broken and that there is something wrong with them, and these messages are coming through health, education, social, and political systems, then there is a good chance they will start to believe it themselves. This has resulted in a culture where people identify themselves with a diagnostic label: “I’m an addict” or “I’m bipolar” are two of many examples. Persons seeking help have been taught for decades that they need to be “helped” by an “expert” which can make recovery-focused empowerment work challenging.

Internalized colonialism, also known as colonial mentality, continues to negatively impact BIPOC communities (Utsey et al., 2014). It has major implications for health and psychology, yet it is not usually the dominant narrative in our healthcare system. Beliefs such as the assumed need for the expert care of a medical professional are a common internalized narrative that focuses on individual symptoms and pathology instead of community supports or other holistic health perspectives. This continues to be the dominant discourse of our health systems which conveniently ignores addressing racism and oppression. For example, our current health system is more likely to avoid addressing the direct and systemic harm caused by residential schools, and instead pathologize and medicate individuals. The training of health professionals still largely ignores decolonization with the exception of short training opportunities that have been piloted in mental health and other sectors.

We must ensure that we are not imposing our values onto marginalized communities which can perpetuate oppression and colonialism even when we have the best of intentions. We must ensure that we avoid engaging in a “white saviour” role with marginalized communities. If we go into these communities to “save” them, we are actively disempowering them and likely causing harm. This is the opposite of recovery values and requires us to think deeply and

intentionally about what empowering a community really means. For example, when co-designing a SCM, all key stakeholder and rightsholder groups need to work synergistically in a manner that is curious and respectful of differences, unites with strengths, and has an equal distribution of power and decision making. If the make up of a co-design group, such as the ones leading SCM implementations, does not have these elements, it runs the risk of being tokenistic and further oppressing marginalized groups. This discussion only paints part of the picture of mental health in Canada and it would be reckless for me to discuss equity, social justice, and decolonization without considering the major gaps that are present between Indigenous peoples and non-Indigenous peoples. Colonization is not a thing of the past; it continues today and is embedded in or society within our structures, approaches, and conceptualizations of health care.

Decolonization and Mental Health

The Truth and Reconciliation Commission of Canada (TRC) published 94 calls to action for the Canadian Government to support the work of reconciliation with the Indigenous peoples of Canada. There are seven calls to action related to Indigenous health, none of which have been completed as of the writing of this document. These calls to action bring attention to the fact that the state of health for Indigenous peoples is a direct result of the Canadian government's policies, including residential schools (Truth and Reconciliation Commission of Canada, 2015). The TRC clearly articulates the human rights of Indigenous peoples which aligns with the *United Nations Declaration on the Rights of Indigenous Peoples* (United Nations General Assembly, 2 October 2007). The TRC suggests working together to create measurable goals to track progress toward closing the gaps between Indigenous and non-Indigenous peoples. Accountability and transparency are important foundations of decolonization and the TRC suggests publishing annual reports and collecting data such as infant mortality rates, maternal health, mental health, substance use, suicide, and life expectancy among others in order to measure our progress toward improving health outcomes. Although my discussion

focuses on the health-related calls to action, other elements in the TRC such as child welfare and education are directly related to health and welfare of Indigenous peoples and the continued oppression that is embedded in the white, dominant culture and systems.

The TRC calls on the Government of Canada to provide sustainable funding for Indigenous healing centres. These centres would help address the physical, mental, emotional, and spiritual harm caused by residential schools. It is important that we understand the history of residential schools but also acknowledge that the harm continues and is reinforced by a colonial and oppressive system. There are still residential school survivors alive today and many more who are impacted by intergenerational trauma that is a direct result of the abuse and cultural genocide caused by government policies, the Catholic Church, and residential schools.

The TRC calls for the Canadian health care system to recognize the value of Indigenous healing practices and actively integrate these practices into patient care when requested. The TRC also calls on the government to increase the number of Indigenous professionals working in health care and provide cultural competency training to everyone. In addition, the TRC calls for medical and nursing schools in Canada to require a course for students that teaches the history and legacy of residential schools, Indigenous health issues, human rights, and anti-racism.

SCMs require health systems to provide a variety of formal and informal service options that promote community strengths, resilience, and choice for individuals (Cornish, 2020). Although SCCG has outlined a nine-step SCM as an example, model development and implementation will look different depending on a community's self-identified strengths and needs. The informal options are often categorized as low-intensity and it is important to remember that this is referring to the resources necessary for the service, not level of importance. For example, a stay in a psychiatric hospital requires more resources than counselling or peer support. Health systems implementing SCM must co-design their own version that is culturally appropriate and relevant for their population. Not all implementation

teams want to design a linear image for their SCM and have chosen to represent their model with a circular image that better represents their system, values, and community. The co-design process must involve key stakeholder and rightsholder groups including community leaders and persons accessing mental health services and their families. What I like about this approach is that it is creative and allows for innovative solutions created by the community itself. It is community empowerment in action.

SCCG does not go into organizations and communities to tell our clients what to do and how to do it. Instead, we support them in capitalizing on their own strengths and help guide the process through the planning, development, and implementation stages of a project. An example of this can be found in a small, rural community in Newfoundland and Labrador. Mental health services were scarce, and access was challenging as people would have to travel far to access professional supports. Some community members got together and started a group they called “knit’n’talk”. Participants would gather at a specified time and do just that: knit and talk. It was a way of supporting each other and feeling connected to a sense of community which we know is positively associated with mental wellness and overall health (Michalski et al., 2020). While it seems simple, one of the SCM principles reminds us that minimal interventions can have positive and impactful results.

It is important that we remain mindful of our assumptions and actions because even with the best of intentions, we can unknowingly cause harm and support oppressive systems. Recovery principles and co-design in SCM are strengths in SCCG’s work and we will continue to find ways to engage and empower the communities we serve. I believe that authentic and servant leadership approaches are particularly valuable here as they focus on the relational aspects of the change process and focus on building trust, respect, and transparency.

Chapter 2: Conclusion

In this chapter, I detailed my chosen leadership approaches through a combination of authentic and servant leadership. These fit well with my work environment and Kotter’s Eight

Stage Change Path Model in combination with PDSA cycles. A critical organizational analysis indicated the strengths and opportunities of my current work context. This helps me make informed choices about feasible solutions to address my problem of practice while remaining in my lane of agency. Lastly, this discussion is framed within a lens of equity, social justice, and decolonization which are all important considerations for this work. Having historical knowledge, listening with humility, and being open to ideas or ways of being that may be new for some people, are steps in the right direction. In chapter 3, I will discuss the implementation, evaluations, and communication of the preferred solution that was discussed in chapter 2.

Chapter 3: Implementation, Evaluation, and Communication

The problem of practice that has been investigated in chapters 1 and 2 is the lack of visioning and strategic planning for recovery-oriented practice in SCMs being implemented in post-secondary settings. To achieve the cultural and system change required by SCM for recovery-oriented practice, an overall vision, strategic plan, and investment in building recovery-oriented practice tools, guides, and implementation plans are needed. After a deeper exploration of the problem of practice from chapters 1 and 2, a critical organizational analysis was completed which led to the preferred solution to address the PoP. A combination of two possible solutions was chosen. Training and resource development and visioning and deepening recovery concepts and research will inform the training development and vice versa. In chapter 3, I will articulate the change implementation plan of the preferred solution. There will also be discussion on the monitoring and evaluation of this change implementation plan, communicating the change process, as well as next steps and future considerations.

Change Implementation Plan

For the purposes of this OIP, change implementation refers to a process that will be executed to implement the proposed solution identified in chapter 2. This process will likely vary which is why I have built in flexibility so I can pivot as needed. While Kotter's (2012) model has been implemented linearly in many settings, there is emerging evidence showing that it can be used successfully in an iterative, non-linear manner (Kang et al., 2022). Implementation science has been widely used to improve patient care in healthcare settings (Jackson et al., 2020; Leeman et al., 2017; May et al., 2016). This change implementation plan contains details about implementation tasks, expected outcomes, and artifacts to be produced and is visually represented in Table 3. These tasks, outcomes, and artifacts are organized around timelines and the 8 stages of Kotter's (2012) change path model. One cycle of change is mapped out for a year but could be adjusted depending on organizational needs or unexpected challenges.

Table 3

Change Implementation Plan

KOTTER'S 8 STAGES	IMPLEMENTATION TASKS	OUTCOME	ARTIFACT	TIMELINE	
Stage 1 Establishing a sense of urgency	Engage leadership and staff. Engagement to include a variety of strategies including individual interviews, group discussions, and consultation with SCCG teams.	SCCG leadership and staff will have knowledge of current gaps in SCM recovery conceptualization.	1. Meeting notes and general summary from individual and group team discussions. 2. Recovery to be a prioritized item on staff meetings and promoted by leadership.	Months 1 and 2	Short Term
Stage 2 Creating a guiding coalition	Build team recovery (combination of synergy and implementation teams) using my influence and well-developed relationships with my colleagues.	The skillset of the combined team members will work collaboratively sharing their visioning and deconstruction of language skills along with their practical application and knowledge translation skills.	1. Team recovery members recruited. 2. Document stating the purpose of the team, terms of reference, and roles of participants.	Month 3	
Stage 3 Developing a vision and strategy	Deepen understanding of what recovery means in SCM and develop a vision that can be translated into an implementation strategy. I will lead this process with authentic and servant leadership approaches.	Recovery conceptual framework that is infused with synergy (diversity, equity, inclusion, decolonization). A plan for implementing the CF within SCCG culture, research, and product development.	1. Visual of recovery conceptual framework. 2. Document detailing strategy for implementation into SCCG.	Months 4 and 5	Medium Term
Stage 4 Communicating the change vision	Presenting to SCCG leadership and staff	Develop communication strategy. Choose communication tactics to implement communication strategy.	1. Blog post on recovery CF. 2. Podcast episode on recovery in SCM.	Months 6 and 7	
Stage 5 Empowering broad-based action	Recovery moment videos Recovery brainstorm sessions	Recovery and mental wellbeing are not only reserved for people with lived experience of mental	1. Video library of recovery moments.	Month 8	

KOTTER'S 8 STAGES	IMPLEMENTATION TASKS	OUTCOME	ARTIFACT	TIMELINE	
		health challenges. This impacts everyone. Thus, all SCCG staff will engage in reflective practice, develop person-first language skills	2. Recovery CF being used in all SCM knowledge mobilization content.		
Stage 6 Generating short-term wins	Communicate short term wins to SCCG leadership and staff.	Deliver training to internal staff on recovery in SCM. Communicate progress and updates to keep internal staff engaged.	1. Internal recovery training that can be used for current and new employees of SCCG.	Months 8 and 9	Long Term
Stage 7 Consolidating gains and producing more change	Reviewing assessment data, leadership, and staff feedback. Debrief with team recovery	Report/articles/ presentations	1. Progress report submitted to SCCG executive team.	Months 9 and 10	
Stage 8 Anchoring new approaches in the culture	Create a broader evaluation plan for the whole change cycle (rather than PDSA cycles for each Kotter phase). This follows the SCM continuous improvement principle.	SCCG staff will be living recovery principles within themselves and their collaborative interactions with others with confidence, a growth-mindset, humility, and empowerment. Recovery principles will be infused synergistically into all areas of SCCG.	1. Recovery CF will serve as a foundational document for all SCCG's training, communications, and knowledge translation products.	Months 11 and 12	

Kotter's Stage 1

Kotter's (2012) stage 1 prioritizes establishing a sense of urgency. While I know that SCCG leadership value recovery principles and consider them to be foundational in SCM, they are trusting me to move things forward as a subject matter expert. They have told me this directly and given me the autonomy to do so. This gives me some leverage and agency as a leader making it easier to implement change. For example, I can decide on implementation tasks, and select a small team to work with me in this change plan with some autonomy. As an authentic and servant leader, I tend to move away from more authoritative roles where I am the sole decision maker or seek to be obeyed by followers (Spears, 2010). I am comfortable making decisions, but I seek collaboration and input from others especially those who will be impacted by the change. My collaborative way of leading fits well with current SCCG practices; however, time constraints along with the challenges of collaborating online can make this difficult. Having flexibility in the change implementation plan along with the combined efforts of my team should help mitigate challenges that arise. I also think that the scheduled PDSA cycles will give me some objective data on which to base my planning and decision making. For example, data collected from a PDSA cycle that is embedded within Kotter's (2012) stages will give me something to communicate implementation progress and address barriers that arise. This will be discussed in more detail in the Change Process Monitoring and Evaluation section of this chapter.

I plan to work with all SCCG staff, including leadership, to build engagement and establish a sense of urgency. The main strategies I will use to support implementing this phase will be conducting individual and group interviews with SCCG leadership and staff, and consult with our internal implementation, synergy, and communications teams. Managing the different needs and expectations of stakeholders in important for a successful change process, and I want to establish these relationships early (Bierbooms et al., 2016). The outcome I hope to achieve is that all staff will have basic knowledge of recovery in SCM, awareness of current

gaps in our organization, and a good understanding on how recovery principles are embedded into their everyday work. Recovery principles may or may not already be embedded in some SCCG work but there is a gap in awareness of what they are and an understanding how these principles directly impact everything the organization does. I will know these goals have been successful when I see that recovery is a prioritized item in meetings and coming up more frequently in team discussions. I expect this stage will take approximately two months and will be an iterative process throughout the whole change implementation.

Stakeholder theory was not chosen for my overall conceptual framework for this OIP due to a variety of reasons. These include the better overall fit of systems and empowerment theories, which represent my worldview and fit well in SCM. Stakeholder theory can offer useful perspectives for the implementation phase of this project and has alignment with synergistic and relational elements my leadership approach and SCM principles. For example, the SCM conceptualization of synergy and interconnectedness, or that any SCM needs to involve all key stakeholders in the co-design process (Cornish, 2020), is aligned with ideas that come from stakeholder theory.

Kotter's Stages 2 and 3

Establishing a sense of urgency will lead into creating a guiding coalition. I will select members from SCCG's synergy, implementation, and communications teams who have an interest and some expertise on recovery, diversity, equity, inclusion, and decolonization, communications plans, implementation, and knowledge translation. Expertise in these areas provides a diverse set of skills and experiences that will allow us to do our work in line with recovery principles and co-design. I will also put out a general call for interest, via email, and meeting announcements, to include anyone from SCCG who may be interested in contributing who has not already been selected. Combining the skillsets from each team member will offer a diverse range of abilities and perspectives that will be valuable as I lead this collaborative process forward. My choice to include a variety of perspectives, some of which may be

divergent, is intentional. Diversity in perspectives, identities, abilities, and experiences have been highlighted in the literature as beneficial to teams, especially those working on complex issues (Bolman & Deal, 2017; Cohen, 2005; Page et al., 2017).

In line with the SCM principle of synergy requiring multi-level collaboration (Cornish, 2020), I see this as an opportunity to practice and work by our own principles and values. Bolman and Deal's (2017) symbolic frame offers useful insight into teams and organizational culture. The authors discuss important ideas to consider for groups and teams including the importance of diversity, leading by example and not command, and the usefulness of narratives, language, and humor (p. 268). Leading by example and collaborative process are a good fit for my authentic and servant leadership approach. For example, van Dierendonck and Sousa (2016) cited the benefits of servant leadership in the context of organizational change and uncertainty. A servant leader will "enhance a sense of meaningfulness through a combination of personal attention and by their ability to relate change to a larger picture that goes beyond the organization" (van Dierendonck & Sousa, 2016). The authors discuss four pathways to creating an environment of meaningfulness including self-connection, unification, contribution, and individuation (van Dierendonck & Sousa, 2016). Mousa, Massoud, and Ayoubi (2020) found that the ongoing orientation of authentic leaders to maintain positive psychological and ethical climates in higher education organizations can promote change management and help reduce individual and group resistance to change. Humor is particularly important to me as it can diffuse tension that naturally arises in group dynamics. This is also important to consider because I am intentionally inviting diverse team members who may have diverging views.

Once team members have been selected, the group will create a document stating the purpose of the team, roles of participants, and terms of reference. My rationale for this document is that it will serve as a foundational reference point for the group's work to help us work effectively and stay on track with our co-created goals. I have allotted month three for this phase which concludes the short-term timeline for the overall implementation. The guiding

coalition will be known as Team Recovery, a term that unites us in our work. Once established, the team will spend months four and five developing a vision and strategy which is Stage 3 in Kotter's (2012) model. The goal of this stage will be to deepen our understanding of what recovery means in a SCM context, deconstruct language and assumptions underlying our understanding of recovery, develop a vision of what recovery implementation infused with synergy in SCMs could look like in the post-secondary context. I will guide this process using the relational skills drawn from authentic and servant leadership approaches (Duignan, 2014; Spears, 2004). For example, my role as a leader in this stage is to build a safe and trusting environment for the team to do this deeper work. This requires empathy, curiosity, good listening, and relationship skills.

One of the artifacts that will come out of this process will be a conceptual framework on recovery principles in SCM. This will include a visual and other knowledge translation tools (e.g. short explainer documents or video) that are accessible for all staff and external stakeholders to use to support SCM implementation. A conceptual framework for recovery and SCM will offer a visual of the key ingredients of recovery in SCM that will be determined by Team Recovery and drawn from both recovery and SCM principles. This visual will also organize the key ingredients in relation to one another to capture the complexities of the different elements and how they relate to each other. This aligns with our overall SCCG work as we present the SCM with several foundational visuals and guiding documents.

Once a conceptual framework is developed, Team Recovery will then create a guiding document detailing strategies for implementation and integration of these ideas into all areas of SCCG's work. The conceptual framework is something that can eventually be share externally to SCM implementors and be used internally as a foundational document that illustrates recovery in SCM. SCCG consultants will be able to use the recovery conceptual framework when planning, implementing, and evaluating SCMs in post-secondary contexts. This will put recovery at the forefront of implementation discussions rather than the current status quo of

focusing on clinical services. Internally, different SCCG teams will be able to use the recovery conceptual framework to inform other work such as trainings, knowledge translation tools, and research.

Kotter's Stage 4 and 5

Communicating the change vision and empowering broad-based action are the 4th and 5th Kotter (2012) stages that conclude the medium-term timeline over approximately three months. Team Recovery will include communication and knowledge translation specialists who can lead the development of a communication strategy. These experts can take the lead when Team Recovery needs to work on communication and dissemination plans and execution. From this strategy, communication tactics may include writing a piece for SCCG's blog and doing an interview on our podcast. The blog and podcast are already established and offer a simple way to engage and leverage our existing organizational strengths.

Empowering broad-based action will require engagement with the larger SCCG team. The goal is to share the recovery conceptual framework and encourage all staff to reflect on how these ideas impact their work. During this time, I will update senior SCCG leadership on our progress and consider any feedback they may have. Recovery and mental wellbeing are not solely reserved for people who have diagnostic labels or have struggled with mental illness. Recovery principles promote wellbeing and can be shared by all individuals and communities. For example, if we revisit Keyes' (2002) dual continuum, we can see that anyone can experience flourishing or languishing mental wellbeing. I will lead this staff engagement by creating video content that discusses recovery in SCM, and hosting brainstorm sessions for us to engage in reflective practice and develop specific skills such as person-first language and moving away from pathology.

At the end of stages 4 and 5, we will see artifacts including a library of video content, and evidence of the recovery conceptual framework being used in all SCM knowledge mobilization content. While these two phases have specific goals and outcomes, I recognize

that this is an ongoing, iterative process. I do not conceptualize Kotter's (2012) model in a rigid or linear manner. In line with SCM principles, models should have some structure with flexibility and a process of continuous improvement. Continuous improvement relies on a solid monitoring and evaluation strategy to obtain regular, timely data to support decision making. Any strategic change requires an awareness of the environment and the context of change. Examples can include people's burdens and their levels of motivation and engagement (Laine et al., 2015). This flexibility allows for rich, context-specific engagement, and the ability to be nimble and adaptable in the face of unexpected barriers to change.

Kotter's Stages 6, 7, and 8

The remaining three stages of Kotter's model (2012) include generating short-term wins, consolidating gains and producing more change, and anchoring new approaches in the culture. These phases span the last four to five months of the implementation plan. Generating short-term wins is something I intend to do whenever an opportunity presents itself during the implementation process. Although generating short-term wins will be intentional and broader in application during this time, I do not see the merit of waiting until month eight to start this stage. Others have identified key factors for change management success including communicating with key stakeholders early and staying engaged in the process (Kho et al., 2020). An example of this kind of engagement could be communicating other successful examples of a similar change process. This is one area where I am challenging the linear presentation of Kotter's model. I do present the phases as linear in Table 3, but I am free to circle back to earlier phases or be engaged in more than one phase at a time.

I will endeavour to consistently communicate short-term wins to SCCG leadership and staff. Not only will this keep everyone informed in a timely manner, but it could also keep the larger group engaged with this project. SCCG has so many projects happening at once that it can be easy to lose focus on anything that is not front and center on a regular basis. The engagement of all SCCG staff can happen in many ways such as group brainstorming meetings

or training. I have already led some brainstorms exploring recovery and other principles of SCM and discussions like this are a regular part of our work culture. This will be explored in more detail in the subsequent section on communication of the change plan.

Months nine and ten of the implementation plan will be focused on the consolidating gains and producing more change. This will entail reviewing all monitoring and evaluation data and assessing overall progress to date. At this time, I will consolidate any ideas or feedback collected from staff that may have not been captured in a formal manner. This will support the continuation of collaborative engagement with the larger group. I will consult with Team Recovery and the create a progress report to submit to SCCG leadership. Other outcomes from this phase may include the writing of reports, presentations, or research articles to broaden our ideas to a wider audience and external stakeholders. Having research and other formalized documents could strengthen SCCG's work and show developing innovative ideas, a balanced critique, and rigorous research and evaluation processes. An example of this could be to publish a paper reflecting on key learnings once the first year of this change implementation plan is complete. Another idea is to propose a research project evaluating the use of the SCM recovery conceptual framework in post-secondary SCM implementations. This could provide us with valuable information that could contribute to future iterations of the framework.

Months eleven and twelve will focus on the final stage of Kotter's (2012) model, anchoring the approaches in SCCG organizational culture. This is another example of how I see a stage working through on its own and throughout the larger change implementation. Looking at the stages of the implementation plan, one can see how I made choices that would lead to embedding these ideas synergistically into SCCG culture. For example, by fostering reflective practice early in the process allows for SCCG staff to embed recovery principles into their themselves and the work they do. Another example is the development of a conceptual framework for recovery in SCM. This visual can be a quick and simple reference for everyone in the organization to use to inform their work. The visual will be developed in stage 3 but will be

communicated in a broader sense including its application in the later stages of the implementation. The conceptual framework can be iterated and improved over time as more people use it and contribute feedback.

We will need to be cautious during these final stages because even if we see changed behaviours, that does not necessarily indicate a change of culture. Making assumptions like this could negatively impact sustaining the change. Anyone leading a cultural shift in an organization will need to understand learning anxiety to support and empower staff to engage with it. While it is easy to quickly label people as resistors to change, there are valid reasons why they may be struggling. Schein and Schein (2016) note several reasons that people may struggle with learning anxiety including “fear of loss of power or position, fear of temporary incompetence, fear of the loss of personal identity, and fear of the loss of group membership” (p. 327). These are understandable fears that could result in avoidance and disengagement from the change process. Identifying and understanding these fears with individuals and groups requires leading with empathy, curiosity, and respect, all of which are components of recovery, authentic leadership (Duignan, 2014), and servant leadership (Spears, 2010). These ideas are also congruent with my conceptual framework that embraces the social construction of reality and the empowerment of individuals and groups (Wong et al., 2019).

By having consistent, research-informed definitions and tools about recovery in SCM, staff may feel more confident and empowered in sharing these ideas and embedding them into their overall work at SCCG. Leadership will have consistent messaging and resources to use in presenting SCM to external stakeholders. The SCCG implementation team will have resources to support implementation of recovery practices in post-secondary settings. It is important to note that any concepts or resources that are developed are not final. SCCG values continuous improvement and with that in mind, our work is an iterative process. New ideas and learning will create different or adapted versions of the work presented in this change implementation plan. I hope that what we have after one cycle of change will be different and improved upon after two

cycles. Now that there is a clear change implementation plan, I will discuss the monitoring and evaluation of the plan in the following section.

Change Process Monitoring and Evaluation

Monitoring and evaluation of change implementation aligns with SCM Core Component 4: Continuous service improvement is achieved through ongoing monitoring and improvement cycles (Cornish, 2020). SCCG values continuous monitoring, failing forward, and learning as we go. Even though our main organizational focus is supporting our clients' monitoring and evaluation of implementation, SCCG strives to live by the same values and principles of the SCM, therefore, I anticipate organizational support for the process I will discuss in detail in this section. Even so, I must consider potential barriers that may arise, such as lack of time due to multiple priorities and shifting deadlines, or challenges of working online. This monitoring and evaluation plan will have built-in flexibility to help address unforeseen challenges.

Monitoring and evaluation are terms that are sometimes used interchangeably which makes defining them important. According to Markiewicz and Patrick (2016), monitoring can be defined as "the planned, continuous, and systematic collection and analysis of program information" (p. 12). Monitoring should also provide information on overall implementation progress. In the case of the proposed change implementation plan, monitoring would include the ongoing, daily work of team recovery staff. Evaluation is also done throughout a project but usually at planned intervals. The goal of evaluation is to use monitoring data to determine if overall program objectives have been met (Markiewicz & Patrick, 2016). The evaluation portion of the change implementation plan will give me the opportunity to understand overall learning process, strengths, and challenges, to guide decisions, new goals, and future iterations of the program.

There are two kinds of evaluation that will be used in this plan, formative and summative. Formative evaluations are created from ongoing monitoring throughout the implementation process. These evaluations will answer specific questions related to implementation progress at

certain stages throughout the plan. This will allow me to evaluate progress while we are still in it and adjust as necessary. Summative evaluations are typically more final and offer data that speaks to the overall progress of the program (Markiewicz & Patrick, 2016). For the purposes of this implementation plan, summative evaluation will take place at scheduled times near the end of the overall project. Table 4 shows the monitoring and evaluation tasks for each Kotter (2012) stage aligned with implementation tasks, outcomes, artifacts, and timelines.

Table 4

Monitoring and Evaluation Plan

Kotter's 8 stages	Implementation tasks	Outcome	Monitoring & evaluation	Artifact	Timeline	
Stage 1 Establishing a sense of urgency	Engage leadership and other stakeholders. Engage internal SCCG staff. Engagement to include a variety of strategies including individual interviews, groups discussions, consultation with SCCG teams.	SCCG leadership will have knowledge of current gaps in recovery conceptualization and implementation tools. SCCG internal staff and teams will have knowledge of current gaps in recovery conceptualization, and an understanding of how recovery principles are embedded in their work.	Monitoring for rational and emotional buy-in from all SCCG staff Formative evaluation: Are people challenging, questioning, and validating need for change? Discussion of risks of status quo? Future talk?	1.Meeting minutes, summaries, and surveys to review. 2. Recovery to be a prioritized item on staff meetings and promoted by leadership.	Months 1 and 2	Short Term
Stage 2 Creating a guiding coalition	Build team recovery (combination of synergy, communication, and implementation teams) using my influence and well-developed relationships with my colleagues.	The skillset of the combined team members will work collaboratively sharing their visioning and deconstruction of language skills along with their practical application and knowledge translation skills.	Monitor for strong sense of purpose, commitment, trusting relationships and team culture. Formative evaluation - Is the group working in true co-design? Does the group have clear goals, trust and commitment? Are diverse voices/viewpoints present?	1. Team recovery members recruited. 2. Document stating the purpose of the team, terms of reference, and roles of participants.	Month 3	
Stage 3 Developing a vision and strategy	Deepen understanding of what recovery means in SCM and develop a vision that can be translated into an implementation strategy. I will lead this process with authentic and servant leadership approaches.	Recovery conceptual framework that is infused with synergy (diversity, equity, inclusion, decolonization). A plan for implementing the CF within SCCG culture, research, and product development.	Monitor for clear sense of direction. Plan – clarifying why vision is necessary Do – Develop the vision Study – Analyze the vision with stakeholder input (e.g. our higher education clients) Act – Integrate stakeholder feedback and create final version of the vision	1. Visual of recovery conceptual framework (CF). 2. Document detailing strategy for implementation into SCCG.	Months 4 and 5	Medium Term
Stage 4 Communicating the change vision	Presenting to SCCG leadership and staff	Develop communication strategy. Choose communication tactics to implement communication strategy.	Plan – Create communication strategy & tactics Do – Implement communications strategy using chosen tactics	1. Blog post on recovery CF. 2. Podcast episode on recovery in SCM.	Months 6 and 7	

Kotter's 8 stages	Implementation tasks	Outcome	Monitoring & evaluation	Artifact	Timeline	
Stage 5 Empowering broad-based action	Recovery moment videos Recovery brainstorm sessions	Recovery and mental wellbeing are not only reserved for people with lived experience of mental health challenges. This impacts everyone. Thus, all SCCG staff will engage in reflective practice, develop person-first language skills	Study – Explore barriers that block staff from using the new vision and CF. Act – Create culture of innovation. Remove barriers preventing engagement Monitoring - for deep understanding of recovery CF. Staff to build recovery language skills.	1. Video library of recovery moments. 2. Recovery CF being used in all SCM knowledge mobilization content.	Month 8	
Stage 6 Generating short-term wins	Communicate short term wins to SCCG leadership and staff.	Deliver training to internal staff on recovery in SCM. Communicate progress and updates to keep internal staff engaged.	Plan – Look for visible/measurable achievements/ performance improvement Do – Achieve and communicate those wins	1. Internal recovery training that can be used for current and new employees of SCCG.	Months 8 and 9	Long Term
Stage 7 consolidating gains and producing more change	Review evaluation data, solicit feedback from leadership, and staff. Debrief with team recovery	Report/articles/presentations	Study – Study key learnings to build on short-term wins, momentum, and credibility. Act - Embed new learning into the future plan. Summative evaluation - Is the change wide ranging and effective? Have program goals been achieved?	1. Progress report submitted to SCCG executive team. 2. Completed short-term wins diagnostic (from Kotter handbook)	Months 9 and 10	
Stage 8 anchoring new approaches in the culture	Create a broader evaluation plan for the whole change cycle (rather than PDSA cycles for each Kotter phase). This follows the SCM continuous improvement principle.	SCCG staff will be living recovery principles within themselves and their collaborative interactions with others, with confidence, a growth-mindset, humility, and empowerment. Recovery principles will be infused synergistically into all areas of SCCG.	Monitor/support sustained change. Leadership modeling new behaviours using the framework. Summative evaluation – Year 1 report with key learnings/actions/wins. Suggestions for year 2 and continuous improvement.	1. Recovery CF will serve as a foundational document for all SCCG's training, communications, and knowledge translation products.	Months 11 and 12	

Along with stage-specific monitoring and evaluation tasks, I will use plan-do-study-act (PDSA) cycles throughout the implementation plan as shown in Table 4 (Donnelly & Kirk, 2015). My goal for integrating PDSA with the Kotter (2012) change path model is to add rigor and validity to the monitoring and evaluation of the change implementation. The first two stages of Kotter's (2012) model do not require the use of PDSA mainly because these are the preliminary stages of the change process. Instead, the primary focus will be on monitoring and formative evaluation to ensure that implementation tasks have been achieved. In stage 1, I will be monitoring for rational and emotional buy-in from all SCCG staff (Cohen, 2005). Rational buy-in refers to making the case for change using solid data (e.g., measurable, quantitative data). Emotional buy-in can be thought of as the compelling narrative that catches people's attention on a deeper and more personal level. The need for change requires logic but must be seen by people so they become emotionally invested. According to Cohen (2005), making the case for change includes 3 elements: (1) situation, (2) problem, and (3) benefits of changing. This can create energy and shared understanding throughout SCCG that could manifest into momentum to drive the change forward (Cohen, 2005).

Evaluating Stages 1, 2, and 3

During the stage 1 formative assessment, I will be looking to see if SCCG staff are asking questions, challenging ideas, and validating the need for change. Assessment of this stage is important to ensure that we have succeeded with our implementation tasks. Rushing through stage 1 is a common mistake when implementing Kotter's model (Pollack & Pollack, 2014). I will also look for discussions about the future of recovery work at SCCG and the risks of maintaining the status quo. I can gain this information from informal conversations with staff and team leaders. I will use meeting minutes and summaries to record the information. The information I gather from the stage 1 formative assessment will inform me if the program is ready to proceed to stage 2 or circle back to fill gaps that were identified in stage 1. If major barriers present themselves in stage 1, I could consider using Cohen's (2005) Urgency

Diagnostic assessment tool as an additional measure (p. 35). This assessment is a survey comprised of 15 items graded on a rating scale, and 6 open-ended feedback questions. I would use this assessment if I noticed SCCG struggling in stage 1 and needed detailed information to understand the barriers so I can make informed decisions to reduce them.

Stage 2 is the part of the implementation plan where I will create a guiding coalition to drive the change forward. I will be monitoring the new Team Recovery for a strong sense of purpose, commitment to the work, and the establishment of trust and cohesion. While Team Recovery may be new, its members will have likely worked together on different projects within SCCG and will be known to each other. Once the team is compiled and before moving to subsequent stages, I will use a series of questions to guide a formative evaluation (Cohen, 2005). Examples of these questions include: Is the group working with cohesion in true co-design? Does each group member have clear roles and responsibilities? Does the group represent diversity in perspectives, abilities, identities, and experiences? It is important that Team Recovery has representation from all internal stakeholders who will be impacted by the change (Seefeldt et al., 2022). As an authentic, servant leader who values relational transparency, I will likely include Team Recovery members in this formative assessment process as I do not believe myself to be the single expert just because I am leading. This aligns with the SCM core component of co-design (Cornish, 2020), and the necessity of collaboration skills and synergy in an effective team (Hawkins, 2022).

Stage 3 of the implementation plan occurs when the visioning and strategic planning work starts, led by Team Recovery. This stage is crucial to addressing my PoP and in the change process as a whole. There will be a full PDSA cycle embedded in this stage in combination with ongoing monitoring for a clear sense of overall direction. During the ‘plan’ part of the cycle, Team Recovery will clarify and deepen the vision of recovery in SCM. From this exploration, the team will move into the ‘do’ part of the cycle by developing a conceptual framework. In this context, a conceptual framework will be used to gain an understanding of

recovery and the visioning of recovery in post-secondary SCM contexts (Varpio et al., 2020). The conceptual framework visual will bring clarity to what the vision is and why change needs to happen. It will be a useful reference tool for our staff as they integrate recovery into their daily SCM work in a more intentional way. My hope is that it will challenge and empower us to think differently, innovate, and continue improving our work over time.

The 'study' part of the PDSA cycle will involve analyzing the vision which is a key approach in Kotter's (2012) stage 3. While this analysis will start with a small group in Team Recovery, it will also include obtaining feedback from internal and external stakeholders. The internal stakeholder will include SCCG leadership and staff. The external stakeholders will include partners outside of the SCCG organization who have expertise in student mental health, recovery principles, lived experience, peer support, and health promotion among others. I will continuously reflect on who we may be missing in our engagement, and the nuanced complexity of different stakeholder contexts and how they impact the information we gather. As with previous stages, I will attempt to obtain feedback from diverse perspectives, identities, and experiences but I must remember that "the value created or sought by stakeholders will differ based on political, social, economic and cultural situational and temporal factors" (Nartey, 2019, p. 268). This is important to promote equity, diversity and inclusivity and will provide rich and varied data for us to use. This data can provide us with ideas and perspectives to inform our vision and strategy that we may not otherwise get.

Examples of this feedback could be notes I take from informal conversations, semi-structured interviews or focus groups. I tend to choose methods that come from qualitative research methodology because the focus on meaning-making, context, and process matters (Maxwell, 2020), and aligns with my conceptual framework and the social construction of reality. To decolonize my own thinking and approaches to work, I will need to be mindful and intentional about how and whom I engage. Team Recovery will need to create space to truly listen and consider all feedback, as well as communicate how and when this feedback will be used. This is

my attempt to move away from tokenistic stakeholder engagement and move toward meaningful dialogue, be prepared for divergent viewpoints, and work with people instead of speaking for them which aligns with the ideas of community-based action research (Gullion & Tilton, 2020) and SCM principles (Cornish, 2020). I will then progress to the 'act' section of the PDSA cycle which will be when Team Recovery integrates stakeholder feedback into a final version of the recovery vision and strategy for SCCG. This will also include sharing the final version with the stakeholders we engaged during this stage in an act of respect and interest in continuous feedback. I am reminded of the *nothing about us without us* call to action from the recovery movement and believe this is one small way of honouring it.

Evaluating Kotter Stages 4 and 5

Kotter's (2012) stages 4 and 5 will include a PDSA cycle split between them. My rationale for doing this is the same as my rationale for conceptualizing Kotter's change path model as iterative and non-linear (Kang et al., 2022). Therefore, I selected the parts of each PDSA cycle for the necessary outcomes of Kotter's stages. Having a complete PDSA cycle in every stage seems rigidly formulaic to me and is unnecessarily arduous. Instead, I have chosen to adapt the cycle to the outcomes and needs of each stage to have them flow together in a logical manner that has some flexibility for unexpected barriers. Meeting context-specific needs is important if I want this change to be relevant and successful.

Kotter's (2012) stage 4 is focused on communicating the newly developed change vision and will include the 'plan' and 'do' parts of the next PDSA cycle. While this is a specific stage in Kotter's change path model, it is a priority at all stages which is part of why I am choosing a communication specialist for the team. This is a priority for me as an authentic and servant leader who values demonstrates relational transparency (Northouse, 2018). Many of us are subject-matter experts at SCCG and have little experience in communication planning or execution. I will need a team member with communications experience to help us communicate regularly, consistently, and effectively. Team Recovery will create and plan a communications

strategy and choose communication tactics to put the strategy into action. This planning will start earlier in the process and be completed and actioned in stage 4. The ‘do’ part of this cycle will be the actual implementation of the chosen communication tactics. Examples of communication tactics include sharing the vision by writing blog posts, articles, or being interviewed for SCCG’s podcast. Communication will be discussed in more detail in the next major section of this OIP.

Empowering broad-based action is the stage of Kotter’s (2012) model where the goal is to see the wider organization starting to implement the vision that was communicated to them in the previous stage. My goal is to have everyone in SCCG engaging in the recovery vision and applying the ideas from the conceptual framework to their own work within the organization. This stage has two priorities: removing barriers impeding people from carrying out the change, and encouraging everyone in the organization to innovate and take calculated risks (Cohen, 2005). Therefore, I will be monitoring and celebrating examples of engagement and innovation and monitoring for barriers that block implementing the vision. The ‘study’ portion of this PDSA cycle will dive into the understanding the specifics of the barriers, and the ‘act’ part will focus on removing or reducing those barriers. This could include things like skills training, coaching, or structural barriers like silos of groups with different work priorities. If we want to create a culture of innovation (Buller, 2014), we need to create an environment that is safe to do so. For example, leadership can intentionally and constructively respond to failure which fits well with SCCG’s ‘fail forward’ mentality.

Evaluating Kotter Stages 6, 7, and 8

Kotter’s (2012) stage 6 involves generating short-term wins. This is another stage that I interpret as fluid and ongoing throughout the change process. Stage 6 in this change implementation plan will include the ‘plan’ and ‘do’ portions of a new PDSA cycle. In the ‘plan’ phase, Team Recovery will monitor for visible and measurable achievements and performance along with other opportunities for short-term wins. The ‘do’ phase will involve achieving and

communicating those wins. While I list stage 6 linearly in this paper, I imagine it as an ongoing, flexible process. Whenever there is an opportunity to achieve and celebrate a short-term win, it can build momentum and buy-in for the change implementation plan. This can be achieved by providing evidence the change plan is working by testing the vision in a real-life context that provides concrete results to keep everyone on board and challenge critics of the change (Cohen, 2005). I may also consider using Cohen's (2005) Short-Term Wins diagnostic tool which is a survey that can be circulated to anyone in SCCG who could offer meaningful feedback (p. 177). Like previous assessments from Cohen's book, this tool includes 16 items using a rating scale and questions for open-ended feedback. This stage provides an opportunity to assess the overall change process while it is ongoing which has been cited as an important aspect of monitoring and evaluating change (Park, 2017). Leaning about the barriers to implementation could offer useful evaluation of the overall progress or the larger change. For example, certain barriers that emerge could indicate a necessity to return to previous stages of Kotter's (2012) model.

Stage 7 involves consolidating gains and producing more change (Kotter, 2012) and includes the 'study' and 'act portions of the final PDSA cycle. Team Recovery will study the key learnings of the change process to build on the short-term wins from the previous stage. Then they will 'act' by embedding the new learnings into the future and longer-term plan. This stage will also involve a summative evaluation that will answer questions regarding outcomes. Questions include, is the change working, wide-ranging and effective? Have the overall program goals been achieved? What evidence is present to support this? If this stage is successful we should be seeing things like a reinvigorated change process with celebrated wins and optimism, additional staff to help continue to move the change forward, and sustained and consistent support from senior leadership (Cohen, 2005). One challenge that may impact the monitoring and evaluation of this stage is that as a new organization, SCCG does not currently have any infrastructure or strategy to measure organizational performance and communication which has

been cited in the literature as key to successful change implementation (Castiglione & Lavoie-Tremblay, 2021). What is encouraging is that SCMs include routine outcome monitoring and assessment (Cornish, 2020) even if the current focus of that work is at implementation sites and in clinical settings as it is in current mental health literature (Boswell et al., 2015). The SCCG value of outcome monitoring has led to the development of unique tools to support our clients, and this could be applied for our own organizational learning.

Lastly, Kotter's (2012) stage 8 focuses on anchoring the new approaches into the organizational culture. During this stage, Team Recovery will be monitoring for continued support and sustained change. We will want to see leaders and other staff modeling new behaviour and using the conceptual framework. The new vision and strategic planning for recovery in post-secondary SCMs will be embedded into SCCG's organizational culture. During this stage, it is important that all stakeholders truly understand and witness the connection between their new behaviours and skills are leading to the overall change and new culture (Cohen, 2005). Culture change is a complex process can be observed through artifacts, values, and basic assumptions (Schein & Schein, 2016). The culture change process will begin at stage 1 and should start emerging by the end of stage 8. Ultimately, this will be a process that continues to iterate and evolve and if we are successful in this change implementation, there will be enough of a foundation to continue building upon.

The end of stage 8 will involve a summative evaluation capturing the overall change implementation process over the past year. A report will be created and presented to SCCG leadership to capture the process, the success, the areas for improvement, and suggested next steps for year 2. I will use more of Cohen's (2005) diagnostic tools including the Making it Stick Effectiveness Checklist, and the Making it Stick Diagnostic (pp.228-229). I find these tools useful as they are tailored to evaluating the specific outcomes of stage 8 in Kotter's (2012) change path model. I have not found any new or updated versions in current literature. I will also consider using internal diagnostic tools if there are any available that would meet the need. I will

include reflections and feedback from Team Recovery to ensure the report is representative of our collective work.

The monitoring and evaluation function of my change implementation plan infuses Kotter's (2012) change path model with PDSA cycles embedded throughout as illustrated in Figure 5. While I will use formal diagnostic tools for assessment, I recognize the importance and value of paying attention to organizational culture which may require some leadership and management of "the direction and evolution of the culture" (Schein & Schein, 2016, p. 126). Culture change will be something I will pay particular attention to as I analyze data collected from monitoring and evaluation. The following section will explore the detailed plan for communicating the change implementation plan and monitoring and evaluation.

Figure 5

Monitoring and Evaluation-Infused Change Path Model

Kotter's Model				
Stages 1-2	Stage 3 PDSA Cycle 1	Stage 4-5 PDSA Cycle 2	Stage 6-7 PDSA Cycle 3	Stage 8

Plan to Communicate the Need for Change and Change Process

Effective communication of the rationale for change as well as the change process itself is just as important as the change implementation plan. Change implementation can fail even if great ideas are developed but the communication strategy falls short (Armenakis & Harris, 2002). Communication needs to be planned, organized, and consistent throughout the change process. It is also important to have a good understanding of an organization's change readiness early in the process so implementation and communication can be planned accordingly (Armenakis & Harris, 2002). This is partly why I chose to use the change readiness

assessment that was described in chapter 1. Like the implementation and evaluation processes, change readiness and communication for this project are conceptualized in a flexible and iterative manner. Two-way communication is going to be an important part of this change process (Armenakis & Bedeian, 1999; Charlotte et al., 2019). This will include communicating key messages throughout the change implementation plan and receiving feedback from key stakeholders.

General Communication Strategy and Tactics

I will not be sharing a finalized communication strategy or tactics in this OIP because it will be co-created by Team Recovery and adapted throughout the change process. Instead, I will continue to share general strategies and tactics I believe could be viable options for us to use for this change implementation plan in the context of SCCG. A communication strategy is the overall change plan directly related to each stage priority in Kotter's (2012) model as discussed in this chapter and earlier versions of Kotter's work (Klein, 1996). This strategy should clearly articulate the 'what', 'why', and 'how' of the change as well as the preferred future state (Beatty, 2015). Communication tactics refer to the actual methods of communicating, the how of the communications strategy. It is important to consider the target audience when choosing a communication tactic so they are engaged in the most appropriate and accessible way (Markiewicz & Patrick, 2016).

As SCCG has grown, leadership has hired marketing and communications specialists, knowledge brokers, and knowledge exchange experts. With this talent has come new and interesting ways of communicating both internally and externally. For example, SCCG has a monthly blog and a podcast that share key concepts of our work that I think will be useful to engage with later in the change implementation process when we engage with both internal and external stakeholders. Because SCCG is a virtual workplace, we rely on communication tools such as video meetings, email, and internal instant messaging. We intentionally use tools other than just email to diversify and increase engagement with each other. In the future, we could

also consider using social media to engage with each other which has been used successfully in other change implementation projects (Naeem, 2020).

Ongoing cycles of two-way communication will offer real-time data that will inform the whole change process. Ongoing monitoring and evaluation will provide useful and timely data for communication efforts throughout the process. Providing clear and consistent communication is an important way that I will honour and respect everyone being impacted by this change process. This aligns with principles of recovery (Mental Health Commission of Canada, 2021a; Slade & Longden, 2015), and my leadership approaches that value relational transparency (Duignan, 2014), and empowerment of everyone in the organization regardless of positional power or status. It is out of this respect of others that I plan to ensure to communicate how their feedback is being used and how it positively impacts the change process. Leadership communication style can have a direct impact on the perceptions of followers and the outcomes of the desired change (Schein & Schein, 2016). Being transparent, using intuitive empathy, and actively inviting feedback whether it is positive or negative, will influence my communication style as a leader. For example, if I respond to negative feedback with a sense of curiosity and respect, others may feel more comfortable engaging in two-way communication once they see it is safe to do so. This requires me to have high levels of self-awareness, humility, and the ability to stay connected to the bigger picture instead of my ego, all of which are hallmarks of my leadership approach (Lafferty et al., 2012/2013).

Luo et al. (2016) studied how leader communication style impacts the management, skepticism, and fear of change in followers. Leadership communication styles need to be adaptable and context-specific to respond to the needs of the followers impacted by the change. Luo et al. (2016) found that certain communication dimensions such as working from hope and support orientations had a positive impact on followers' affective commitment to a change process (p. 256). These findings align with Cohen's (2005) emphasis on gaining both rational and emotional buy-in from stakeholders in stage 1 of Kotter's (2012) change path model.

If one has delivered a well-crafted message, this does not mean that it has been heard or had the desired effect and understanding. Therefore, open communication cycles are critical to change implementation success. The feedback we receive will give us regular information about how our messages are interpreted or any gaps in communication that need to be addressed. This section will discuss communication strategy, priorities, and tactics broken down into three sections spanning Kotter's eight stage model. Each of Kotter's (2012) stages have their own communication needs that work synergistically with the implementation goals and tasks to be completed. In the following section, I will discuss communication needs for the various Kotter stages.

Communication and Kotter's Stages 1-3

The first three stages of Kotter's (2012) model include creating a sense of urgency, building a guiding coalition, and developing a vision. The goal of these early stages is to create a climate for change. It is important to nurture an engaging process with those who will be impacted by the change, and this can be done creatively using narratives and real-life experiences. It is the foundation that the remainder of the steps will be built upon. Creating a sense of urgency is a stage that relies heavily on effective communication and involves the whole organization. Cohen (2005) offers us key considerations for communication including building awareness about the issues or gaps present in order to demonstrate the need for change and maintaining open lines of communication at all levels to ensure that leaders present with a consistent, unified message. It is also important to think about who needs to hear what information at what time and intentionally include this in the communication strategy. For example, key stakeholders who will be directly impacted by the change may need to be a communication priority early in the change process while the wider organization may not.

Creating a guiding coalition is the priority in Kotter's (2012) stage 2. It is crucial that I bring the right people together to move this change forward. I will intentionally recruit at least one member from SCCG's marketing and communications team to benefit from their expertise

in creating messages and getting them out there effectively. Work moves so quickly at SCCG with multiple projects being managed that it is very easy to speed through this foundational stage. Even with pressures like this, I hope to have enough autonomy as an informal leader to make time for these important steps.

Part of communication in Kotter's (2012) stage 2 involves ensuring that everyone in the organization knows who the leaders of the change implementation are and what roles they play in the process (Cohen, 2005). This will be easier to accomplish with a clear and consistent communication strategy (Charlotte et al., 2019). Each member of Team Recovery needs a solid understanding of their own role and must assume responsibility for communicating the need for change. This will help continue building the sense of urgency and momentum that will drive the change forward. Part of supporting two-way communication throughout the change process will involve the change leaders of Team Recovery taking the necessary time to listen and understand people's fears and concerns of the incoming change (Cohen, 2005).

Ki (2015) argues that we must include relationship cultivation in communication strategies which can include things like access, positivity, openness and disclosure, task sharing, and networking. It is important for everyone to feel heard and engaged throughout the change process. This is another example of the importance of relational transparency skills that I draw from authentic leadership approaches (Northouse, 2018). This is basic respect and will also ensure buy-in and momentum for the change implementation. Understanding fears and criticisms of the change is important to the success of the change. For example, when people who could be labelled as disruptors express criticism, the first response at SCCG is to directly engage them. We welcome divergent views into our process because we believe that working together in synergistic co-design will produce a better result.

Kotter's (2012) stage 3 focuses on developing the vision. Communication of that vision is just as important as the vision itself (Cohen, 2005). In the beginning, SCCG was a small collective of researchers, clinicians, and subject matter experts in mental health. There were

plenty of great ideas to explore but not necessarily the means or the skills to communicate them. Luckily, over the past 16 months, SCCG has expanded and hired new talent that help us develop, market, and communicate to external stakeholders. Their knowledge and skills are beneficial to us internally at SCCG as we continue to grow and develop our organization. On the other hand, everyone on Team Recovery will be responsible for strategic communication and leaving everything up to the communication experts goes against the SCM principle of experts not holding all the wisdom (Cornish, 2020). A holistic approach that is inclusive of leadership, managers, and colleagues may be a better fit for SCCG and other complex organizations such as higher education institutions (Heide et al., 2018), especially if the communication strategy is co-designed.

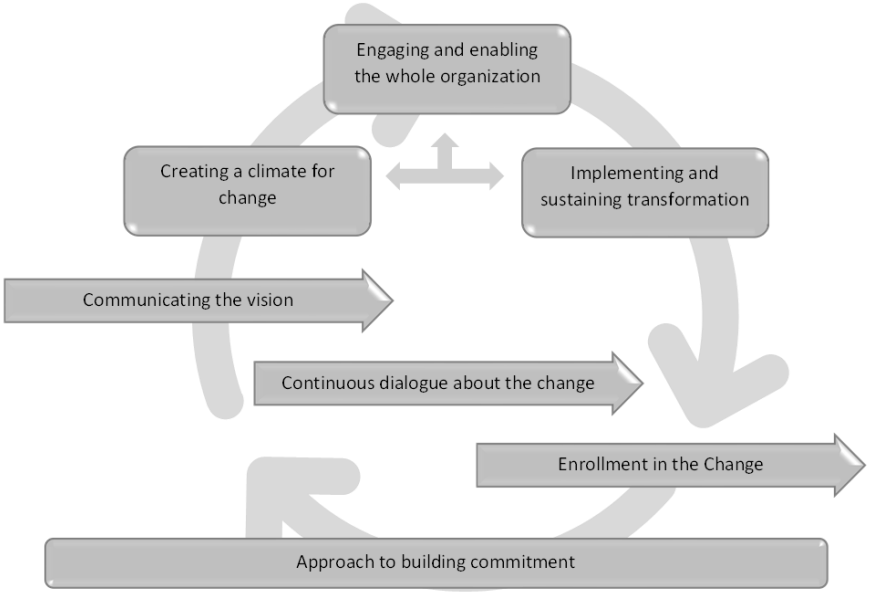
It is important that communication regarding the change process is planned and starts early so it is well established by the time we arrive at Kotter's (2012) stage 3. At this point, key elements of the change should have already been communicated to the organization (Cohen, 2005). Once Team Recovery has completed a vision draft, it will need to be communicated to all stakeholders to ensure its feasibility, invite feedback, and identify gaps to be addressed. Once the feedback has been collected and integrated into the vision, the communication priority will become reporting back to the stakeholders who contributed. It is important that the stakeholders see this as an open and iterative process and offers details about how their feedback has been incorporated. Even though the implementation is in early process at this point, it is important to communicate what you know in a timely manner and fill in knowledge gaps later (Beatty, 2015). This transparency will help with buy-in, engagement, and trust in the people leading the change effort. Team Recovery will have to create a communications plan that welcomes ongoing feedback and engagement, and shares progress updates with the whole organization. This will need to be strategically emphasized as a continuous process much like the continuous improvement principle in SCM (Cornish, 2020; Cornish et al., 2017).

Communication and Kotter's Stages 4-6

Engaging the whole organization in the change process is the theme of Kotter's (2012) stages 4, 5, and 6. Communicating the vision for change that was created in stage 3 will continue to be applied, but to the entire organization, rather than only key stakeholders. The goal of stage 4 is to communicate to build buy-in to the change. According to Cohen (2005), there are three key activities for this stage: (1) initially communicating the vision, (2) engaging in continuous dialogue, and (3) enrolling stakeholders in the change effort (p. 107). Some of these activities would have started on a smaller scale in stage 3 but would now be in full force spanning the organization in Stage 4 as illustrated in Figure 6 (Cohen, 2005, p. 107). This figure shows the cyclical, iterative and interactive nature of Cohen's approach to building commitment. This visual will help in the establishment of communication priorities and objectives throughout the implementation process.

Figure 6

Approach to Building Commitment



Strategies for communication in this stage could include informative and persuasive approaches. Informative strategies are usually based more on objective data and can be useful when a behavioural change does not have to happen immediately while persuasive strategies appeal to a person's values and emotions (Werder, 2014).

Once the change vision has been communicated effectively in stage 4, Kotter's (2012) stage 5 prioritizes enabling action throughout the organization. One major implementation task at this stage is removing barriers staff may experience in the change process. Having open and engaging two-way communication is important to better understand the barriers individuals face when implementing the change vision into their work, and learn about what is working well, so we can create environments that set people up for success (Charlotte et al., 2019). I look forward to stage 5 because this is where we get to work collaboratively as an organization to innovate and improve. Cohen (2005) encourages us to use humor in our communication at this stage and create a sense of fun. This can help with the natural anxiety that comes from change and contribute to an environment that welcomes trying new things and not reverting to the status quo.

Stage 5 will bring SCCG together synergistically to engage in a creative space to explore new ideas and integrate them into everyday work. Team Recovery will be responsible for transparent communication across SCCG. We will communicate success stories while also communicating lessons learned from attempts that may not have gone as well. Supporting staff engaged in either of those experiences will be of the upmost importance. If staff are not supported when a perceived failure happens, they may not be as willing to continue learning and trying new things which would not be in alignment with the SCM principle of failing forward.

Stage 5 will flow into Kotter's (2012) stage 6 which focuses on creating short-term wins. I perceive these two stages as working simultaneously and the smooth flow of the work will rely on effective communication and engagement. The implementation task for stage 6 is focused on creating short-term wins and communicating them is equally important. We are still dealing with

the uncertainty of the COVID-19 pandemic and the very busy context of the SCCG organization, which could create barriers to communication that we will have to anticipate (Seefeldt et al., 2022). The communication objectives for stage 5 include gaining credibility, building support for the effort, and demonstrating clear examples that progress is occurring (Cohen, 2005, p. 171). The key messages of the communication should include demonstrating how short-term wins validate the vision, clear connection of the win to the change process, and continuing to maintain momentum by celebrating success, with enthusiasm and excitement (Cohen, 2005). In planning for this stage, it will be important for Team Recovery to find out what concerns stakeholders might have by using a variety of tactics such as anonymous surveys and interviews. We can use this knowledge to address areas of concern directly in our communication content, and offer ideas of how to communicate specific issues with stakeholders (Beatty, 2015).

Generating and communicating short-term wins is crucial to the long-term success of the change implementation plan. We need to remember the importance of two-way communication at this stage because we cannot assume that our messages are being received the way we think they are. We also need two-way communication to facilitate the continuous feedback loop that provides us with important information about barriers and experiences of anyone impacted by the change (Kotter et al., 2021). Cohen (2005) encourages us to intentionally seek feedback from resistors of the change in order to facilitate two-way communication which is also a practice of SCCG. Sometimes people interpret messages differently even if we believe our communication is short, effective, and clear. This will help ensure that everyone feels engaged in the process without alienating those who are skeptical or resistant to the change. Two-way communication will also give us useful information to evaluate our communication strategy and adjust as needed. Naeem (2020) suggests that we can make strategic use of social media platforms to promote engagement and communication which could lead to the success of

change efforts. This could apply well to SCCG as we already use a social media platform for communication, and we have a digital workplace.

Communication and Kotter's Stages 7-8

The final two stages of Kotter's (2012) change path model focus on longer term implementation and sustainability of the change. Stage 7 focuses on consolidating wins and creating more change while stage 8 prioritizes sustaining the change. A declining sense of urgency could impede sustaining the change long-term (Seefeldt et al., 2022). It could be easy at this point to assume the change process is complete after a few short-term wins (Cohen, 2005). At this point, two-way communication should be well-established in SCCG's culture and the change implementation process. The lines of communication should remain open and will be a vital resource sustaining the change in the long-term. Because of the fast-paced, digital work environment at SCCG, plus the management of multiple projects and deadlines, it could be tempting to move on too quickly without setting a solid foundation for the sustainment of the change we have worked so hard for.

Cohen (2005) describes the complexities of communication at stage 7 by explaining that different parts of the organization will be in different stages of change. This will require managing simultaneous communication tasks. For example, one SCCG team may need communication-focused buy-in and explaining the vision while another team may need communication support for short-term wins objectives. This is the complex reality of organizational change and another reason why having established communication strategies in place is necessary. Stage 7 is also when communication with external partners and stakeholders will begin as the change continues to be applied broadly. This will require establishing new tactics to facilitate two-way communication. In this case feedback will be received and acted upon, however it will be in more of a consultative role (Heide et al., 2018). At this point in the change implementation, the overall vision has been achieved and the focus will

be on communication the broader vision, while receiving feedback to fuel the continuous improvement process.

The priority of Kotter's (2012) stage 8 is to make the change stick. The change should be embedded into organizational culture at this point. As a change leader at SCCG, my most powerful tool is good relationships and leading by example. When leaders are visible role models and mentors, this can contribute to shifting organizational culture. While Team Recovery and I would be modelling these leadership behaviours throughout the change process, at this point I would like to be seeing others engaging in the same behaviour. For example, senior leadership and project managers could all be using the new recovery vision and framework while engaging in role modelling behaviour. This could significantly boost our more formal communication efforts. This chapter outlined one cycle of change mapped out for one year. This serves as a starting point for change implementation. In the following section I will consider possible next steps and future considerations.

Next Steps and Future Considerations

The change process outlined in this chapter will happen over the span of one year and will represent one cycle of change. In this section, I discuss my reflections of possible next steps and future considerations after the change implementation. For next steps, I would like to explore using the recovery conceptual framework at several implementation sites and measure progress. Secondly, I would like to start a research project measuring whether the CF used in SCM implementation results in an increase in recovery-oriented practices. Lastly, I would like to engage the Synergy Team to see how the recovery CF aligns with their work and look for opportunities to apply it to ourselves as an organization. Future considerations include building bridges between SCCG and substance use recovery communities, exploring decolonizing research with recovery principles, and contributing to academic literature. My hope is that by engaging in more writing and research in recovery-oriented practices, we can continue our growth in this area and ultimately have a broader impact with our work.

Next Steps

There are a lot of exciting possibilities to explore with this work. First, I will be using the learning gained in our one-year change process and apply it to our external partners at post-secondary implementation sites. Even though post-secondary organizations are complex in nature, I believe key learnings from our process will help us support others engaging in this kind of change. I would like to study the use of the recovery CF at several SCM implementation sites and measure progress. This would offer SCCG some real-life application data that could further aid us in supporting our clients with recovery implementation. From there, I think it would be useful to study whether the recovery CF facilitates a greater adoption of recovery-oriented practices at post-secondary SCM implementation sites. The results could have strong implications for the future of recovery implementation work in SCMs and would contribute to the general recovery literature.

Second, I would like to contribute to the mental health literature. SCCG has ongoing research projects, a few published articles, a book, and a book in progress, and we have written several rapid reviews for future publication. I would like to co-author a piece about recovery language with a peer from the substance use community. Substance use recovery and mental health recovery programming and literature are still siloed with only a few exceptions (Substance Use and Mental Health Services Administration, 2010). Building bridges and writing with my peers in the substance use recovery community could contribute to a more integrated conceptualization for us all moving forward. Recovery has a role to play in decolonizing research and there is much opportunity to explore it with diverse ways of knowing. I see the potential of another research project or paper exploring these recovery principles in SCM and what they could offer decolonizing mental health systems while also contributing to the decolonization of research itself.

A third step could be partnering with the Synergy Team at SCCG who work to deconstruct terms such as diversity, equity, and inclusion, challenges us to think in ways that

are more inclusive and considerate of diverse ways of knowing and being. I have already noticed my work in recovery overlapping with the work of the Synergy Team and think there are great opportunities to be explored together.

Working in a rapidly growing organization with a fast-paced environment is both challenging and exhilarating. It is much too easy to complete a task and move on to the next thing. I can move forward with the lessons learned from Kotter's (2012) stages 6, 7, and 8 that focus on sustaining change in the long-term. I also believe that there are endless opportunities to engage with ideas around recovery principles and making the mental health system work for everyone.

Future Considerations

First, I think it will be important to continue building bridges with diverse recovery communities especially ones focused on substance use. Substance use has long been marginalized by the mental health community, examples of which can be found in how professionals are trained and the structural stigma that is deeply ingrained in mental health systems. For example, van Boekel et al. (2013) found that healthcare professionals tend to have negative attitudes towards patients struggling with substance use to the extent that it led to negative health outcomes, and patients who felt disempowered. We can see it in policies, structures, and language. Dual diagnosis, comorbidity, and co-occurring disorders are used to describe people experiencing mental illness and struggling with substance use in the mental health system (Guest & Holland, 2011). These labels automatically indicate that a person has had issues with substance use and can contribute to the stigma, alienation, and discrimination, in society and with healthcare professionals (van Boekel et al., 2013). Even though persons experiencing mental illness often have similar experiences, we need to listen to, and respect our peers in the substance use recovery community. We need to do more work together as a whole recovery community as I have found we are often talking about the same ideas of hope, empowerment, and self-determination. I would like to do collaborative work with substance use

peers that focuses on recovery in order to discuss the strengths and connection between our communities.

While I plan to engage more with SCCG's Synergy Team in one of my next steps, I also believe that thoughtful, longer-term work is necessary. If we are really doing the work of decolonization and promoting equity, diversity, and inclusion, we must commit to the deeper work. This is the primary focus on the Synergy Team, and I think collaboration could result in using recovery-oriented practices as a vehicle for this to take our work in this area further. The more we do our own work as an organization, the better we will be able to support our clients and the mental health community at large.

Chapter 3: Conclusion

In this concluding chapter of my OIP, I offer the 'how' of the changes I propose to address my PoP. An implementation plan based on Kotter's (2012) change path model lays the foundation of the process. Details of the implementation tasks are based on the needs of SCCG and the priorities of each Kotter stage. PDSA cycles are embedded into the change path model to support monitoring and evaluation tasks at different stages of the change process. Lastly, a thoughtful and intentional communication strategy is implemented at the beginning stages and evolve over time to meet the needs of SCCG, and ensure the change is successful. Next steps and future considerations include widely applying the lessons learned from our own recovery implementation to our clients at various stages of SCM implementation. Evaluating the impact the recovery conceptual framework has on recovery-oriented practices through research will give this work more credibility in the academic literature. Partnering between the mental health and substance use recovery communities will be important to this work moving forward. We can contribute to the deconstruction of pathological labels and lead the way for the health system to engage in this paradigm shift towards recovery.

Narrative Epilogue

Like most doctoral students, I had many ups and downs throughout my program. As I did my work, I often had conflicting, dual experiences. On one hand, I have been writing about recovery with a sense of hope and enthusiasm that comes from my passion for this work and my belief in the strengths of others. On the other hand, I have daily struggles that take my energy, hope, and optimism from me. I often feel like a hypocrite writing about the power of people with lived and living experience of mental health challenges while feeling hopeless, broken, and flawed myself. This is a good representation of the dichotomy so many of us live with. I can hold onto hope and power while experiencing mental health symptoms that tell me otherwise. I still hang onto my diagnostic labels even though I face barriers carrying them. This is part of the beauty and complexity of being human. It hurts and it makes us who we are.

This is the first time that I registered as a student with a disability. I had not disclosed this in the past for a variety of reasons such as the need to protect myself, and the belief that my struggles were personal flaws that did not deserve accommodations. In consultation with my family doctor, I made the choice to register reluctantly. I had both positive and negative experiences with this label throughout my program. The continuous reality check that I get from my physician is an important part of my recovery. The expected stress from being a student who also works full time, and the unexpected stress that came from the pandemic is a lot for most people to handle. What is different for me is how easily this stress can spiral and make me unwell for long periods of time. I had months of depressive episodes throughout this program. I experienced trauma triggers that set me back significantly. I am truly grateful to be working with a supervisor who understands me as best as he can, and truly listens on a deep level. Never underestimate the power of patience, respect, and meeting people where they are. I am also grateful for the relationships I have formed with my cohort colleagues. This only reinforces the power of community and how we all benefit from it. Without these supports, I would not have completed this program.

Now that I have written this Organizational Improvement Plan using recovery language, I would like to take a moment to deconstruct it. Earlier in this document, I discussed the differences between medical and personal recovery that come from Mike Slade's work. One of the problems with recovery language is it implies that one is recovering *from* something that is wrong with them. We have a culture where we heavily rely on professional expertise to diagnose and treat our issues. Moving away from this and toward self-determination and empowerment is a slow process like any major paradigm shift. We have professionals that are trained to assess and treat problems, and we have a population that expects this. The most common thing that people think of when I say the word recovery is a person recovering from a substance use disorder. Both the mental health and substance use recovery communities have much in common but remain separated in discourse, programming, and academic literature. Substance use recovery sometimes refers to abstinence-based programming which is not aligned with harm-reduction approaches to health. I do not believe that people should have barriers to access help based on whether they are using substances or not. If those barriers are present, then there should be enough options for help-seekers to make choices that meet their needs. This is what SCM is all about.

I experienced high levels of stress and self-induced pressure to "get it right". As a someone who identifies with the recovery community on such a personal level, I could not let myself make a single mistake for fear of causing additional harm to people who already face so much. I cognitively understand that this is impossible and illogical but try telling that to my heart and spirit. I do not speak for everyone in mental wellbeing field or recovery communities. All I can do is my best work at any given time, open myself to others with humility, and continue along my life's journey.

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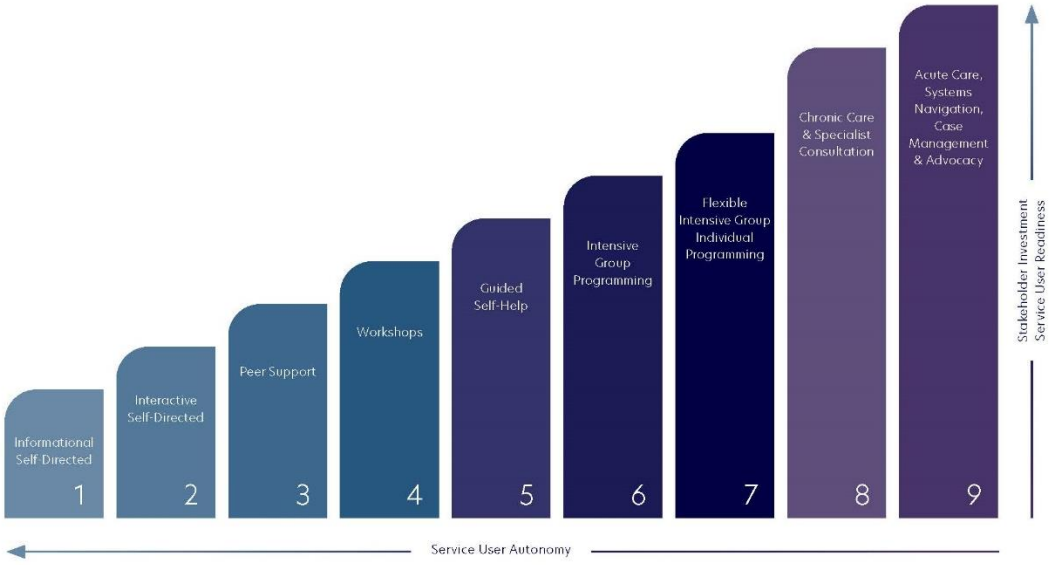
Appendix A: Stepped Care Model



SCM is organized around the full continuum of care, with nine steps ranging from Step 1: Informational Self-Directed Care to Step 9: Acute Care, Systems Navigation, Case Management & Advocacy. The implementation of SCM involves selecting services, such as e-mental health interventions, self-guided support, peer support, group programming and in-person therapy, that align with these steps. Care elements associated with the nine steps are organized along three dimensions:

1. Stakeholder investment: Stakeholders include persons seeking help, providers, and funders. As intervention intensity increases, a greater investment (i.e., time, effort, and cost) is required to achieve positive results.
2. Service user autonomy: As step levels and intervention intensity increases, the amount of autonomy correspondingly decreases. While autonomy is greatest when service users are using lower step resources, which include activities they can do on their own, at higher steps, service users require more assistance. At Step 9 for example, in the case of involuntary hospitalization, service user autonomy is much lower.

3. Service user readiness: As step levels increase, service users need to be ready, willing and able to engage in the associated higher intensity programming (Cornish et al., 2020).

The nine steps of SCM are:

1. Informational self-directed
2. Interactive self-directed
3. Peer support
4. Workshops
5. Guided self-help
6. Intensive group programming
7. Flexible intensive group and individual programming
8. Chronic care and specialist consultation
9. Acute care, systems navigation, case management and advocacy

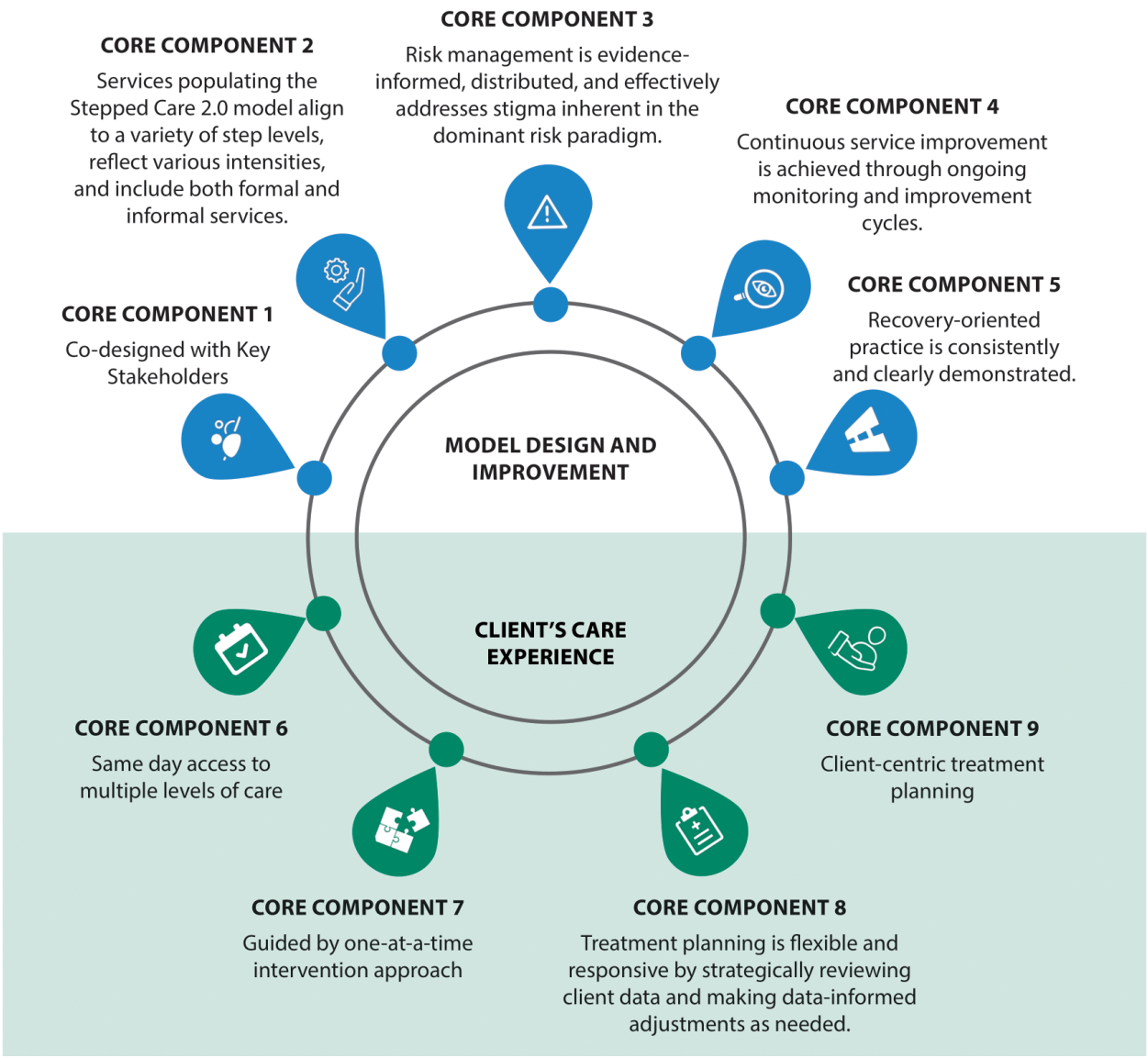
SCM is framed around the following ten guiding principles and nine core components (Cornish et al., 2020):

1. Social justice drives effective care system transformation and is an intervention in itself.
2. Multiple and diverse care options are required as one approach will not work for everyone.
3. All individuals and communities have strength and capacity.
4. People engage with what they are ready to do; gold standard intervention is that which best fits the service user at any given time.
5. Professionals do not carry all the wisdom; people often know what is best for them.
6. Mental health literacy is required for people to make informed decisions.

7. An effective care system ensures people have access to care when and where it is needed.
8. The whole is greater than the sum of the parts: the strength of the system relies on multilevel collaboration.
9. Minimal interventions can produce powerful results.
10. There is no ideal solution; trial-and-error leads to growth and change.

A non-linear example of the SCM being used in an Atlantic Canadian province:

Appendix B: SCM Core Components



Appendix C: Change Readiness Assessment

Readiness Dimensions	Readiness Score
Previous Change Experiences	
1. Has the organization had generally positive experiences with change?	If yes, score +1
2. Has the organization had recent failure experiences with change?	Score - 1
3. What is the mood of the organization: upbeat and positive?	Score + 1
4. What is the mood of the organization: negative and cynical?	Score - 2
5. Does the organization appear to be resting on its laurels?	Score - 1
Executive Support	
6. Are senior managers directly involved in sponsoring the change?	Score + 2
7. Is there a clear picture of the future?	Score + 1
8. Is executive success dependent on the change occurring?	Score + 1
9. Has management ever demonstrated a lack of support?	Score - 1
Credible Leadership and Change Champions	
10. Are senior leaders in the organization trusted?	Score + 1
11. Are senior leaders able to credibly show others how to achieve their collective goals?	Score + 1
12. Is the organization able to attract and retain capable and respected change champions?	Score + 2
13. Are middle managers able to effectively link senior managers with the rest of the organization?	Score + 1

14. Are senior leaders likely to view the proposed change as generally appropriate for the organization?	Score + 2
15. Will the proposed change be viewed as needed by the senior leaders?	Score + 2
Openness to Change	
16. Does the organization have scanning mechanisms to monitor the environment?	Score + 1
17. Is there a culture of scanning and paying attention to those scans?	Score + 1
18. Does the organization have the ability to focus on root causes and recognize interdependencies both inside and outside the organization?	Score + 1
19. Does “turf” protection exist in the organization?	Score - 1
20. Are the senior leaders hidebound or locked into the use of past strategies, approaches, and solutions?	Score - 1
21. Are employees able to constructively voice their concerns or support?	Score + 1
22. Is conflict dealt with openly, with a focus on resolution?	Score + 1
23. Is conflict suppressed or smoothed over?	Score - 1
24. Does the organization have a culture that is innovative and encourages innovative activities?	Score + 1
25. Does the organization have communication channels that work effectively in all directions?	Score + 1
26. Will the proposed change be viewed as generally appropriate for the organization by those who are not in senior leadership roles?	Score + 2
27. Will the proposed change be viewed as needed by those who are not in senior leadership roles?	Score + 2

28. Do those who will be affected believe they have the energy needed to undertake the change?	Score + 2
29. Do those who will be affected believe there will be access to sufficient resources to support the change?	Score + 2
Rewards for Change	
30. Does the reward system value innovation and change?	Score + 1
31. Does the reward system focus exclusively on short-term results?	Score - 1
32. Are people censured for attempting change and failing?	Score - 1
Measures for Change and Accountability	
33. Are there good measures available for assessing the need for change and tracking progress?	Score + 1
34. Does the organization attend to the data it collects?	Score + 1
35. Does the organization measure and evaluate customer satisfaction?	Score + 1
36. Is the organization able to carefully steward resources and successfully meet predetermined deadlines?	Score + 1
Scores can range from - 10 to + 35. The purpose of this tool is to raise awareness concerning readiness for change and is not meant to be used as a research tool. If the organization scores below 10, it is not likely ready for change and change will be difficult. The higher the score, the more the organization is ready for change. Use the scores to focus your attention on areas that need strengthening in order to improve readiness. Change is never “simple”, but when organizational factors supportive of change are in place, the task of the change agent is manageable. This change readiness assessment was taken from Cawsey, Desca, and Ingols (2016).	