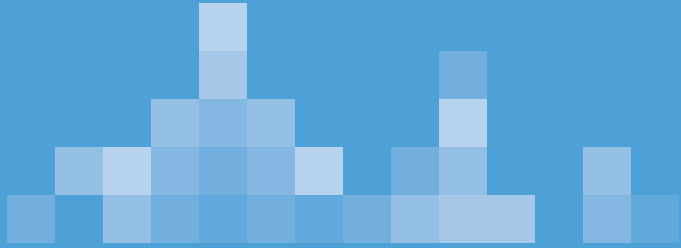


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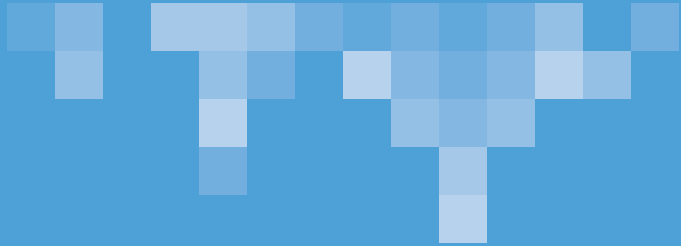
Commission de
la santé mentale
du Canada

Recovery-oriented practice
An implementation toolkit





Recovery is possible for everyone,
and hope is the ground on which
recovery is built.



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Introduction

The *Guidelines for Recovery-Oriented Practice* (Guidelines) provide an in-depth Canadian resource for understanding recovery and for promoting consistent use of recovery principles in mental health care.¹

This toolkit was created to help those who provide mental health and substance use services and supports adopt the Guidelines into their unique workplace contexts and practices. It gives practical examples of how the core recovery principles show up in organizations through policies, programs, and practices.

The structure of the toolkit was informed through an online national survey, in-person consultations, and key informant interviews with those who work or have worked in the mental health or substance use fields, as well as service users and caregivers.



The full Guidelines and recommendations are available from the [MHCC's Recovery page](#).

What is recovery?

Recovery in mental health and substance use is about people living satisfying, hopeful lives and contributing to society even if they experience ongoing symptoms of a mental health problem or illness. It looks different for everyone, so people should be empowered to decide what recovery means for them and what they need to achieve it.²

Why recovery-oriented practice matters

The actions, choices, and behaviours of anyone providing mental health and substance use services or supports can have a significant impact on service users and how they experience care.

Everyone deserves respect, dignity, and the opportunity to live a life consistent with their hopes, goals, and aspirations. These are our collective human rights.

Recovery-oriented practice instils hope, and empowers and sustains the recovery journey by building upon people's strengths, passions, and purposes.³



[It's really about well-being](#): An article on harm reduction



[Toward a shared vision for mental health and addiction recovery and well-being](#): An article presenting an integrated two-continuum model

Who the implementation toolkit is for

All people in the health services system, regardless of their role, profession, discipline, seniority, or degree of contact with people using services, play a role in fostering recovery in their organizations and practice.⁴

This toolkit can be used by

- **senior executives** (e.g., for scope of governance)
- **practitioners and clinicians** (e.g., for client- and family-centred care, professional development)
- **people with lived or living experience of mental health problems or illnesses and/or substance use and their families** (e.g., for co-production, peer support, advocacy)
- **educators** (e.g., for training, skills development, evaluation)
- **systems leaders** (e.g., for system transformation, system partnerships)
- **managers** (e.g., for leading practices, performance coaching)
- **decision makers** (e.g., for resource allocation, funding).

Much like the Guidelines, this toolkit is meant for all organizations, whether they are just starting to think about adopting a recovery-oriented approach or have already done significant work in this area.



¹ Mental Health Commission of Canada. (2015). *Guidelines for recovery-oriented practice* [PDF]. https://www.mentalhealthcommission.ca/sites/default/files/2016-07/MHCC_Recovery_Guidelines_2016_ENG.PDF

² Mental Health Commission of Canada. (2020). *Putting recovery into practice: An introduction to the guidelines for recovery-oriented practice* [PDF]. https://www.mentalhealthcommission.ca/sites/default/files/2021-01/putting_recovery_into_practice_eng.pdf

³ Mental Health Commission of Canada. (2020).

⁴ Mental Health Commission of Canada. (2020).




How to use the implementation toolkit


The toolkit is a flexible, interactive tool filled with resources showcasing how to use the Guidelines and apply recovery-oriented approaches within various types of organizations and settings.


As a first step, consider becoming familiar with the Guidelines and recovery principles. This toolkit was informed by the Getting Started and Measuring Progress section of the Guidelines (pp. 92-96), which provides a brief summary of how to put recovery-oriented practice into action.

The toolkit includes eight case studies, sharing how recovery-oriented practice has been put into action in a variety of contexts. Explore these case studies to discover lessons learned and find inspiration to implement recovery approaches in your own practice.


The toolkit also includes a range of tools and resources that may be useful for implementing recovery-oriented practice. Click on the accompanying icons to access these tools and learn more.


 Information is available within this document.

 Information is linked outside of this document.

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 Video

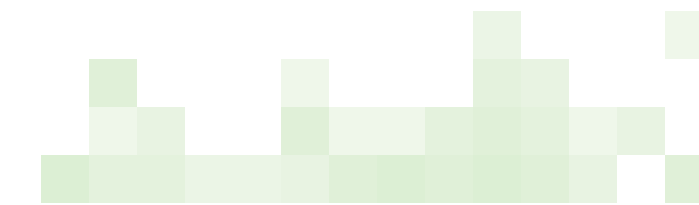
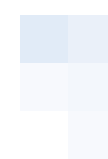
 Assessments or Evaluations

 Training and Education

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 Template

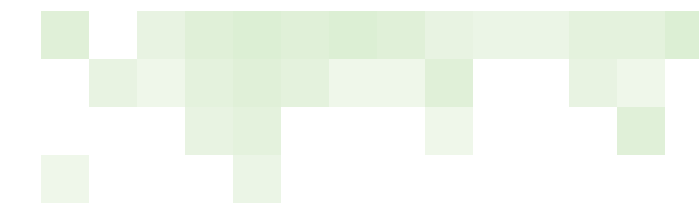
 Additional Reading



Section 1: The six dimensions of recovery-oriented practice

Recovery-oriented practice has six dimensions, each of which is supported by its own guidelines. Use this section of the toolkit to:

- become familiar with each dimension
- read stories about the impact each dimension has on people with lived and living experience of mental health problems/illnesses and/or substance use, and on health-care services
- explore examples showcasing how organizations have fostered each dimension.





Dimension 1: Creating a culture and language of hope

Including hopeful language in all organizational policies and practices helps create a mental health system foundation that is geared toward fostering recovery. Read a story about the impact this dimension can have.



Impact Story: **Holding onto hope for them until they're ready to hold it themselves**

There are points in time when patients need us to hold onto hope for them until they are ready.

I learned this while working on a forensic unit in a mental health hospital...



"Hope": A music video about hope



Hope T-shirt: A mental health awareness campaign



Wall of Hope: An online forum of Hope messages



Dimension 2: Recovery is personal

Recovery-oriented practice recognizes every person's uniqueness and right to determine their own path to mental health and well-being. It supports people's individual journeys to wellness and helps them lead satisfying and purposeful lives in their communities of choice. Health-care workers put people at the centre of mental health and substance use practice and partner with them to build on their strengths and foster autonomy.



Impact Story: **We need to be exposed to people who believe in us**



Video Stories: A playlist of personal recovery stories



Resource: 100 Ways to Support Recovery



Dimension 3: Recovery occurs in the context of one's life

Fostering recovery requires understanding people in the context of their lives. Family, friends, neighbours, local community, schools, workplaces, and spiritual and cultural communities all influence mental health and well-being and can play an important role in supporting recovery.



Impact Story: **Every path to recovery is unique**

When my brother was first experiencing psychosis, I wanted him to recover so that he could graduate high school, go to college, have a job, and get married...



WrapAround: A mental health support plan for families



AMI-Quebec: Support for families



Centre for Innovation in Peer Support: Peer-led social connections program



Dimension 4: Responding to diverse needs of everyone living in Canada

Recovery-oriented practice is grounded in principles that encourage and enable respect for diversity and that are consistent with culturally responsive, safe, and competent practices. It appreciates the rich diversity of Canada's population to better respect the choices people make in their recovery processes and determine how best to adapt services to meet their needs.



Impact Story: **The principles of recovery are a bridge back to the world**



Bridge the gap: Support for youth



AMI-Quebec: Organizations that support cultural and ethnic communities



Dimension 5: Working with First Nations, Inuit, and Métis

Many principles grounded in Indigenous knowledge and cultures — such as promoting self-determination and dignity, adopting a holistic and strengths-based approach, fostering hope and purpose, and sustaining meaningful relationships — also form the foundation of a recovery orientation. Recovery-oriented practitioners recognize the distinct cultures, rights, and circumstances of First Nations, Inuit, and Métis, and understand how recovery for Indigenous people is uniquely shaped by Canada's history of colonization.

Understanding that it is imperative that Indigenous people, communities, and Nations lead the work to create a toolkit that is effective for them, further consultation and engagement will be needed for the development of a separate toolkit, addressing these specific needs, processes, and relationships.



Dimension 6: Recovery is about transforming services and systems

Achieving a fully integrated recovery-oriented mental health and substance use system is an ongoing process that will take time to implement. Recovery is a journey not only for people living with mental health problems or illnesses and/or substance use (and their families), but for everyone involved in providing supports and services. Commitment to recovery needs to be embedded into everything an organization does, including instilling the skills and resources for recovery-oriented practice in its workforce.



Impact Story: **Building a new identity and vision oriented to recovery**



Recovery Declaration: A public commitment to Recovery



Journal of Recovery in Mental Health: A peer-reviewed journal of recovery research



Understanding the dimensions of recovery-oriented practice

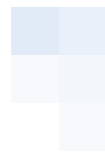
Additional Resources



For an introduction to the Guidelines, see [Putting Recovery into Practice: An Introduction to the Guidelines for Recovery-Oriented Practice](#).



For a full list of the skills, behaviours, values, attitudes, and knowledge required to implement all six dimensions, see the complete [Guidelines](#).



Section 2: How to take action

Once you understand the six dimensions of recovery, the next step is to put them into practice. Following the principles of implementation science can help ensure success. Use this section as a guide to:

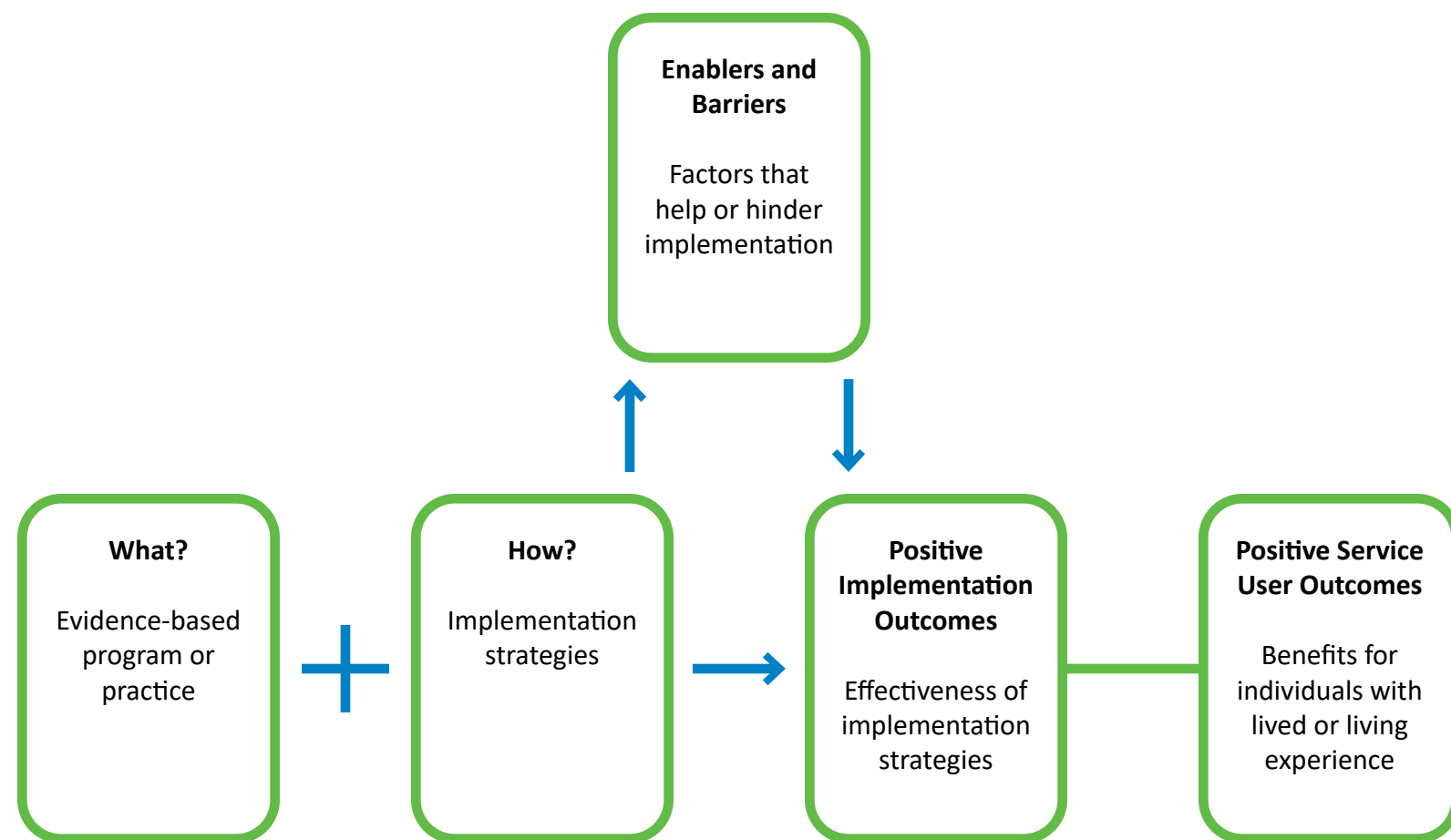
- develop a step-by-step plan to improve recovery-oriented practice
- put recovery-oriented practice into action using a variety of strategies
- learn how to measure the positive effects of the strategies and recovery-oriented practice.



What is implementation science?

Implementation science is a method for turning best practices into actions. It asks organizations and individuals to consider *what* needs to change, *how* the change will happen, and what *enablers* and *barriers* exist that could help or hinder the change. This process leads to *positive outcomes* for service users through successful completion of the implementation plan.⁵

Figure 1: General factors in implementation science



Source: Adapted from Hateley-Browne et al. (2019).

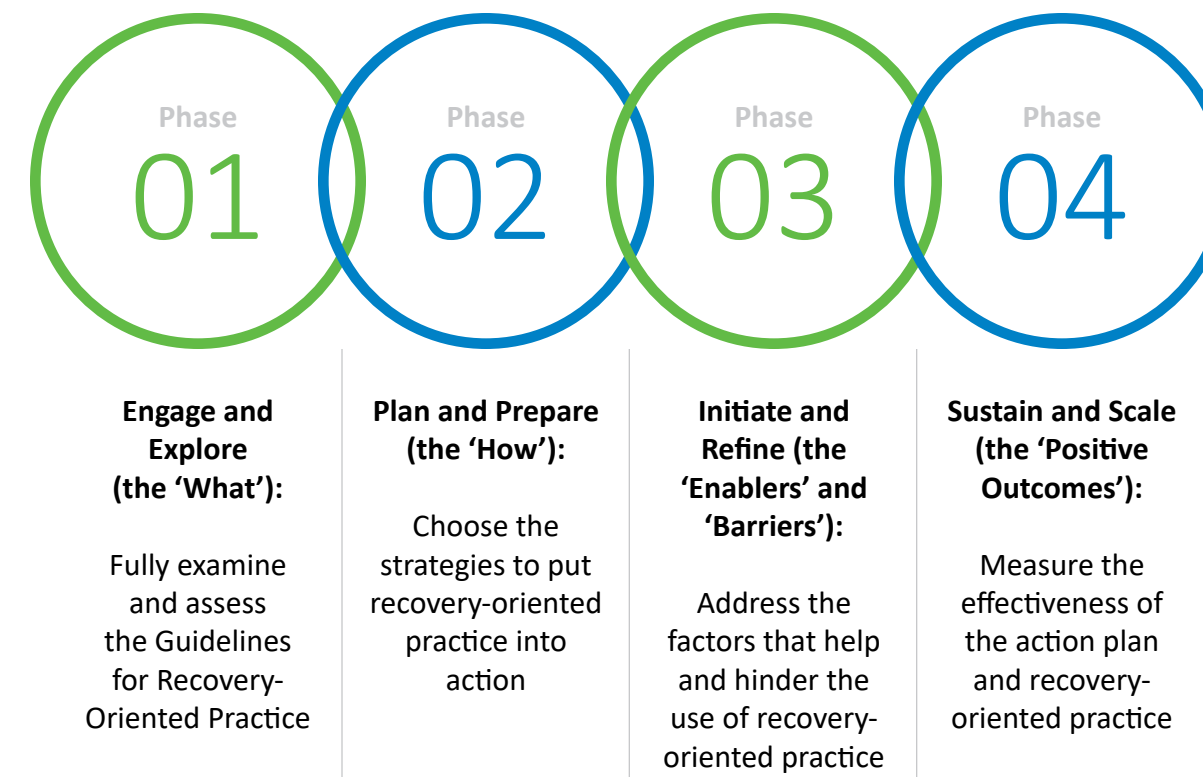
⁵ Hateley-Browne, J., Hodge, L., Polimeni, M., & Mildon, R. (2019). Implementation in action: A guide to implementing evidence-informed programs and practices [PDF]. https://aifs.gov.au/cfca/sites/default/files/publication-documents/1906_implementation_in_action_1.pdf

Four phases to taking action

Applying implementation science to recovery-oriented practice involves four distinct phases of work, each of which focuses on a different set of activities. The process is not necessarily linear, and phases may overlap. An organization that has already started to adopt recovery-oriented practice may skip ahead to a different phase in the process.⁶

As Figure 2 shows, the four phases cover the *what*, the *how*, the *enablers* and *barriers*, and the *positive outcomes* of implementation science. Phase 1 is all about getting oriented and informed; Phase 2 involves planning in a clear and methodical way for success; Phase 3 brings the way forward into focus; and Phase 4 provides a framework for measuring how effective the exercise has been.

Figure 2: The four phases of taking action



Change and transition

A thoughtful action plan for implementing recovery-oriented practice will consider how to support people through change. Any change puts people into a state of transition. Transition is felt internally and requires people to go through a period of mental adjustment as they start to use recovery-oriented approaches.⁷ If the transition is not addressed, the plan to apply recovery-oriented practice could fail.

Source: Adapted from Hateley-Browne et al. (2019).

⁶ Hateley-Brown, et al. (2019).

⁷ Bridges, W., & Mitchell, S. (2000). Leading transition: A new model for change. *Leader to Leader Journal*, 16. https://www.researchgate.net/publication/265082185_Leading_Transition_A_New_Model_for_Change



The importance of co-production in putting recovery principles into action

Co-production engages people with lived and living experience of mental health problems or illnesses and/or substance use as equal partners who jointly identify opportunities and create solutions to improve health-care services. Co-production aligns with recovery principles, including working in partnership, taking a strengths-based approach, and valuing everyone's participation. It is important to use co-production throughout all four phases of taking action because it is an expression of recovery-oriented practice in and of itself.



[Co-Production – Sharing Our Experiences, Reflecting on Our Learning](#): A briefing from ImROC



[Co-Production in Mental Health](#): A literature review commissioned by Mind

Taking action: Phase 1: Engage and explore

The next several pages of the toolkit provide detailed sets of activities for each implementation phase. They also list key tools and resources for further guidance and support. Here are some tips and steps for getting oriented:

Start the plan with the following steps:

- Launch a co-production process with people who have lived and living experience of mental health problems or illnesses and/or substance use, and their family members.
- Review the Getting Started and Measuring Progress" section of the Guidelines (pp. 92-96).
- Set up a team to be responsible for the implementation process.
- Read through the Guidelines carefully.
- Assess the current state of recovery-oriented practice in your organization using an assessment tool or external evaluator.
- Define what and who needs to change based on the assessment.
- Describe who the changes are for and how they will benefit.
- Consider the clinical outcomes service users will experience and the metrics to be used to evaluate them.
- Get buy-in from key stakeholders such as executive leaders, board members, peer support workers, sponsors, and funders.
- Consult with other organizations that are leading in recovery-oriented practice.
- Conduct a change readiness assessment with all employees.
- Brainstorm the factors that will help put recovery-oriented practice into action.
- Brainstorm the factors that might hinder the plan to put recovery-oriented practice into action.

Questions to consider during Phase 1

- What problems are we trying to address by adopting recovery-oriented practice?
- What are we trying to improve with recovery-oriented practice?
- What would be different if we successfully implemented the core recovery principles in our organization?
- What metrics can we use to measure the success of our plan to put recovery-oriented practice into action?
- What metrics can we use to measure the benefits of recovery-oriented practice on our service users?
- What does the research say about recovery-oriented practice and the six dimensions of recovery?
- What specific knowledge and actions do we want to demonstrate by adopting the Guidelines?
- How can we partner with people who have lived and living experience of mental health problems or illnesses and/or substance use to co-produce our plan to improve recovery approaches?
- What can we learn about recovery-oriented practice from other people or organizations such as researchers, caregivers, the community, service providers, and policy makers?

Tools and resources for Phase 1

- The MHCC's [Guidelines for Recovery-Oriented Practice](#) include competencies, reflection questions, and resources to assess the current state of recovery-oriented practice.
- The [Sustainability Model](#), by the NHS Institute for Innovation and Improvement, has been customized to assess the current state of recovery-oriented practice at the process, staff, and organizational levels.
- The [Organizational Change Readiness Survey Template](#) can be used to assess change readiness at the organizational, team, and individual levels.
- [Promoting a Recovery-Focused Workplace: Getting the Right People in the Door](#), by Edye Schwartz, offers insights on measuring performance related to recovery-oriented practice as well as guiding questions to assess your organization's culture of recovery.
- [Innovation to Implementation: A Practical Guide to Knowledge Translation in Healthcare](#), by the MHCC, is a how-to resource for driving change to put new practices into action in health care.
- The [Co-Production – Sharing our Experiences, Reflecting on our Learning](#) briefing paper describes how to engage people with lived and living experience of mental problems or illnesses as equal partners in creating change toward recovery-oriented approaches.



Taking action: Phase 2: Plan and prepare

This is a significant stage of the process, shaping your implementation plan. Part of this phase involves choosing implementation strategies in five key areas: strategic planning, training and education, leadership, performance improvement, and employee engagement. You can find more detail about that aspect of Phase 2 on [page 13](#).



Develop the plan with the following steps:

- Create a detailed action plan that shows
 - what strategies will be used
 - what needs to be done
 - where changes need to happen
 - how they are to happen
 - who is responsible.
- Choose the implementation strategies that will work best for your organization, including some from each of the five key areas in Section 3:
 - strategic planning
 - training and education
 - leadership
 - performance improvement
 - employee engagement
- Select the implementation outcomes and the metrics that will be used to measure and evaluate the effectiveness of the plan.
- Decide when and how often implementation outcomes will be measured during the process.
- Decide when and how often clinical outcomes will be measured during the process.
- Get the organization ready to use recovery-oriented practice by preparing resources, training, support, and infrastructure.
- Identify a pilot group of practitioners who will start using recovery-oriented practice according to the Guidelines.
- Develop a change management plan to support the pilot group through the transition.

Questions to consider during Phase 2

- How will we measure the success of our plan to put recovery-oriented practice into action?
- How will we measure the benefits of recovery-oriented practice to our service users?
- How can we engage people as agents of change to adopt recovery-oriented practice?
- Which implementation strategies are available to us?
- Which implementation strategies will work best for our people?
- Which implementation strategies are most appropriate for the services we provide?

Tools and resources for Phase 2

- See Implementation Strategies on [page 13](#).
- The MHCC's [Recovery Declaration](#) provides an opportunity to publicly commit to working toward a fully recovery-oriented health system.
- The [Team Recovery Implementation Plan](#), by ImROC, provides an assessment tool and an action plan to help teams implement recovery-oriented practice in their unique context.



Taking action: **Phase 3: Initiate and refine**

This is the point where the plan gets put into action.



Put recovery-oriented practice into action with the following steps:

- Introduce the changes to the pilot group and have them start using recovery-oriented practice.
- Continuously monitor and analyze the implementation and clinical outcomes.
- Adjust the plan based on outcomes achieved or not achieved.
- Introduce new implementation strategies as needed to support the pilot group in their adoption of recovery-oriented practice.
- Remove barriers that hinder the pilot group in their adoption of recovery-oriented practice.
- Use a Plan-Do-Study-Act cycle until the desired outcomes have been achieved and the changes to practice are the new normal for the pilot group.

Questions to consider during Phase 3

Enablers

- How have people shown acceptance of recovery-oriented practice?
- How have people shown that recovery-oriented practice is effective and important?
- What parts of the plan have been successful?
- How have the organization, the health-care system, and the community shown that recovery-oriented practice is possible?
- How have peer support workers been engaged to train and educate others about recovery-oriented practice?
- How have people with lived and living experience of mental problems or illnesses and/or substance use been engaged in improving recovery approaches?

Barriers

- How have people pushed back against recovery-oriented practice?
- What policies, procedures, systems, attitudes, and assumptions are getting in the way of people fully putting recovery-oriented practice into action?

Tools and resources for Phase 3

- The MHCC's [Guidelines for Recovery-Oriented Practice](#) include competencies, reflection questions, and resources to help you put recovery into action.
- The [Certified Psychosocial Rehabilitation Recovery Practitioner](#) designation and training from PSR Canada provide practitioners with education on recovery-oriented practice.
- The briefing paper [Preparing Organisations for Peer Support: Creating a Culture and Context in Which Peer Support Workers Thrive](#), by ImROC, provides guidance on using peer support as an enabler of recovery-oriented approaches.
- The briefing paper [Peer Support Workers: A Practical Guide to Implementation](#), by ImROC, offers a step-by-step guide to implement peer support as an enabler of recovery-oriented approaches.
- The [Enablers and Barriers](#) document presents some success factors and potential challenges to implementation.



Taking action: Phase 4: Sustain and scale

This last stage contributes to continuous improvement and a clear understanding of progress.



Maintain momentum and expand recovery oriented practice with the following steps:

- Build on the knowledge, skills, and abilities of the pilot group to further recovery-oriented practice.
- Introduce the changes and recovery-oriented practice to new groups, practitioners, sites, and contexts.
- Use the RE-AIM framework to monitor the implementation and clinical outcomes of the adoption of recovery-oriented practice:
 - **Reach:** The number of practitioners with the skills, knowledge and willingness to participate in recovery-oriented practice
 - **Effectiveness:** The benefits to individuals with lived and living experience (measures “positive service user outcomes”)
 - **Adoption:** The level to which practitioners use the six dimensions of recovery in their daily practice
 - **Implementation:** The level to which recovery-oriented practice has been adopted as intended according to the implementation plan and the Guidelines
 - **Maintenance:** The level to which the six dimensions of recovery are integrated and ongoing among your organization’s practices and operations
- Re-assess the current state of recovery-oriented practice in the organization regularly to begin a new implementation cycle.

Questions to consider during Phase 4

- What do our metrics show about our plan? Was the plan successful?
- What do our metrics show about how our service users have benefited from recovery-oriented practice? Is our practice successful?
- What does the RE-AIM framework show about the success of the plan and recovery-oriented practice?
 - **Reach:** Did our service users experience recovery-oriented practice? Did our practitioners put recovery-oriented practice into action?
 - **Effectiveness:** Did recovery-oriented practice have the intended benefits?
 - **Adoption:** Was recovery-oriented practice used by practitioners? Does the organization demonstrate recovery principles?
 - **Implementation:** Did the strategies used to put recovery-oriented practice into action work according to plan?
 - **Maintenance:** Has recovery-oriented practice become a regular way of providing mental health and substance use care over the long-term?

Tools and resources for Phase 4

- The [Review of Recovery Measures](#) is a publication from Australia that reviews the available recovery measures for mental health services.
- The [Recovery Assessment Scale](#) is a 20-item self-reflective assessment used to measure an individual’s view of their recovery.
- The [CHIME Framework](#) uses five items (connectedness, hope, identity, meaning, empowerment) to describe personal recovery from mental illness.
- The [Recovery Knowledge Inventory](#) assesses knowledge of and attitudes toward recovery-oriented practice among mental health service providers.
- The [Recovery Promoting Relationships Scale](#) is an instrument designed to measure practitioners’ competence to facilitate recovery through their attitudes, skills, and strategies.
- The [Recovery Promotion Fidelity Scale](#) is a 12-item measure organized around five recovery domains to evaluate the level to which an organization has integrated recovery principles into its services and operations.
- The briefing paper [Supporting Recovery in Mental Health Services: Quality and Outcomes](#), by ImROC, helps organizations in the health sector develop clear individual and organizational recovery outcomes.

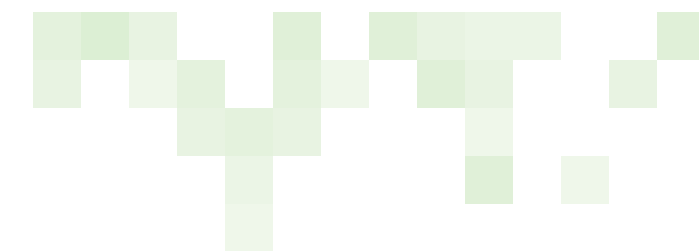


Section 3: Implementation strategies

This section of the toolkit takes a closer look at various implementation strategies you might choose to support for the five key areas of:

- strategic planning
- training and education
- leadership
- performance improvement
- employee engagement.

For each area, you will also find some suggested tools and resources to support your efforts.



Strategic planning

Here are some strategies you can use to support your planning efforts:

- Assess the current state of recovery-oriented practice in your setting using the Recovery Promotion Fidelity Scale or the [Sustainability Model](#).
- Assess your organization's change readiness and identify barriers.
- Visit other sites and learn from those who have adopted recovery-oriented practice.
- Try out changes with a pilot group, refine the change process, then scale to other groups.
- Conduct focus groups and interviews with service users about recovery-oriented practice to discover areas of strength and opportunity.
- Involve service users as partners to help co-design and develop a formal action plan to adopt recovery-oriented practice.
- Identify and prepare recovery-oriented practice champions.



Ontario Shores' [2017-2022 Strategic Plan](#) includes specific goals related to recovery-oriented practice and uses patient artwork to represent each of its strategic directions.



The [Recovery Promotion Fidelity Scale](#) is a 12-item measure organized around five recovery domains to evaluate the level to which an organization has integrated recovery principles into its services and operations.



The [Sustainability Model](#), by the NHS Institute for Innovation and Improvement, has been customized to assess the current state of recovery-oriented practice at the process, staff, and organizational levels.

- Educate and engage board members and senior leaders about the social and economic benefits of recovery-oriented practice.
- Build partnerships and communities of practice with other like-minded organizations to share resources and adopt recovery-oriented practice together.
- Develop academic partnerships to help translate recovery research and knowledge into practice.
- Access new funding to support recovery-oriented practice.
- Change physical structures and equipment to reflect recovery-oriented approaches and dimensions as warranted.
- Leverage family councils and patient advisory councils to amplify the voice of lived experience in your organization.
- Include recovery-oriented practice in long-term strategic goals.



[Recovery: The Business Case](#) is a useful resource from ImROC.



[Recovery Communities of Practice: An Innovative Strategy for Mental Health System Transformation](#) is an article that appeared in *Psychiatric Services* in 2016.



[Introduction to Psychiatric/Psychosocial Rehabilitation \(PSR\): History and Foundations](#) is an article that appeared in *Current Psychiatry Reviews* in 2013.



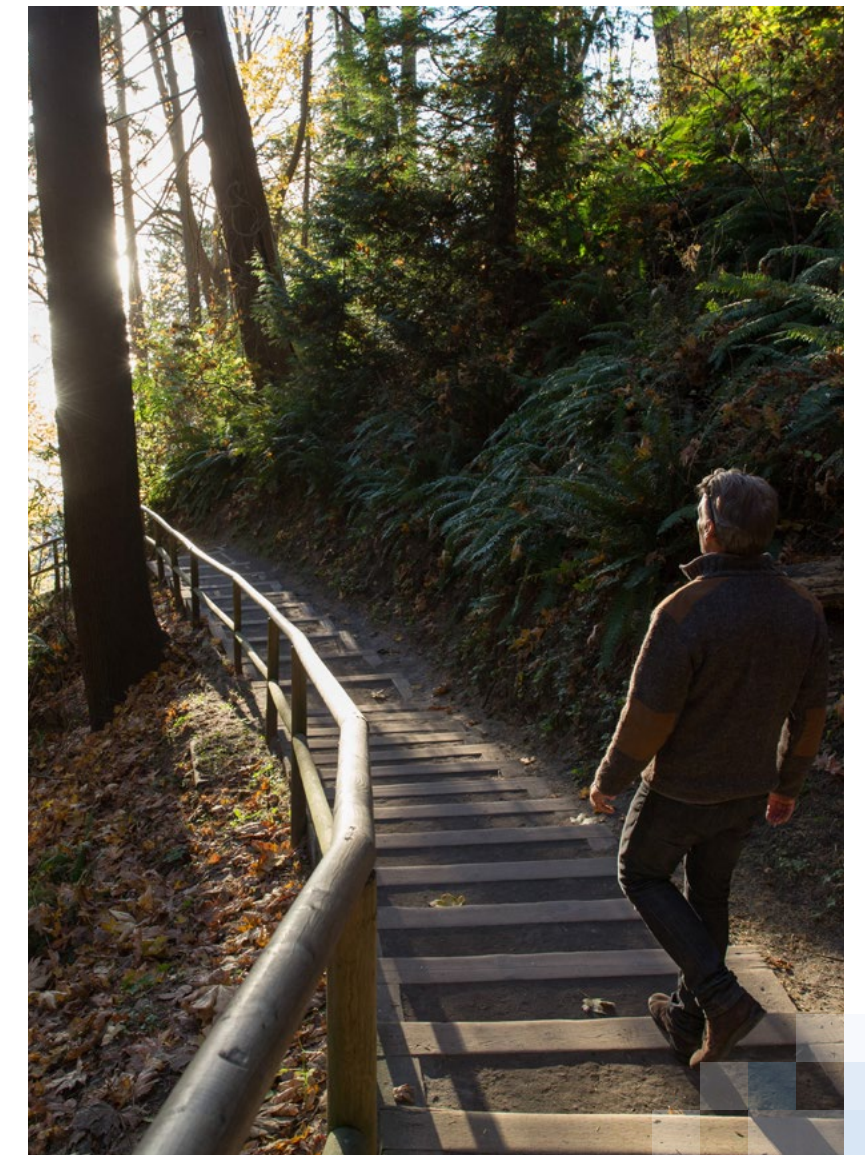
[Peer Support Workers: A Practical Guide to Implementation](#) describes the phased approach to engaging people with lived and living experience of mental health problems or illnesses as a way to enhance recovery-oriented approaches.



[Co-Production – Sharing our Experiences, Reflecting on our Learning](#) describes how to engage people with lived and living experience of mental health problems or illnesses as equal partners in creating change toward recovery-oriented approaches.



The MHCC's [Recovery Declaration](#) provides an opportunity to publicly commit to working toward a fully recovery-oriented health system.



Training and education

Here are some strategies you can use to develop training and education programs:

- Develop educational materials about recovery-oriented practice.
- Conduct education outreach visits with other sites to show recovery-oriented approaches in practice.
- Use train-the-trainer strategies to sustain education and knowledge transfer on recovery-oriented practice.
- Provide ongoing consultation for recovery-oriented practice.
- Conduct ongoing and advanced training in recovery-oriented practice.
- Host educational meetings on recovery-oriented practice.
- Distribute educational materials and job aids about recovery-oriented practice.
- Inform local opinion leaders of recovery-oriented approaches.
- Create a learning community around recovery-oriented practice.
- Provide opportunities for job shadowing clinicians in recovery-oriented practice.
- Use mass media to share recovery stories.
- Prepare service users and their families and friends to be advocates of recovery-oriented practice.
- Work with educational institutions to incorporate recovery-oriented practice into undergraduate curricula for practitioners.



The [Certified Psychosocial Rehabilitation Recovery Practitioner](#) designation and certification from PSR Canada provide confidence that individuals have the skills and competencies to deliver recovery-oriented practice. Ongoing education and training are also available.



The [Competencies of Practice for Canadian Recovery-Oriented Psychosocial Rehabilitation Practitioners](#), by PSR Canada, are a way of assessing the knowledge, skills, and attitudes needed to perform recovery-oriented practice.



[Recovery-Oriented Education and Training](#) provides an overview of the difference between recovery education and training, while emphasizing the use of co-production.

Leadership

Here are some strategies your leadership team can use to support your implementation planning:

- Recruit a recovery-oriented practice specialist to train your leadership team.
- Identify executive leader sponsors to support recovery-oriented practice implementation plans and changes at the highest level.
- Equip leaders to consistently communicate recovery approaches and use recovery language.
- Support leaders to model and value recovery-oriented approaches and the use of recovery language.
- Allocate resources and funds to support recovery-oriented practice and approaches.
- Fund and contract specialists to support recovery-oriented practice innovation.
- Launch corporate-wide action plans to implement recovery-oriented practice in your organization.



The MHCC's [Guidelines for Recovery-Oriented Practice](#) includes reflection questions specifically to help leaders assess the current state of recovery-oriented practice.



The organizational practices for [Mental Health Services](#) from Accreditation Canada provide leaders with standards for mental health care and recovery approaches, such as client- and family-centred care and co-production.



Performance improvement

Here are some strategies you can use to support performance improvement throughout your organization:

- Investigate accreditation or membership requirements related to recovery-oriented practice.
- Revise professional role descriptions to require the use of recovery-oriented practice.
- Hire new practitioners with experience in recovery-oriented practice.
- Conduct recovery-oriented practice competency assessments.
- Embed recovery-oriented practice competencies into performance appraisals and performance management procedures.
- Develop tools for monitoring the quality of recovery-oriented practice.



The [Promoting a Recovery-Focused Workplace: Getting the Right People in the Door](#), by Edye Schwartz, is a how-to resource for various performance improvement strategies for recovery-oriented practice. It includes interview questions, job descriptions, and performance measures.



The [Competencies of Practice for Canadian Recovery-Oriented Psychosocial Rehabilitation Practitioners](#), by PSR Canada, are a way of assessing the knowledge, skills, and attitudes needed to perform recovery-oriented practice.

- Work with service users to enhance uptake and participation in recovery-oriented practice and approaches.
- Use data experts to extract and interpret data related to recovery-oriented practice.
- Centralize technical assistance related to recovery-oriented practice tools and resources.
- Purposefully re-examine the implementation plan.
- Schedule reminders for clinicians about changes to recovery-oriented practices.
- Audit charts and provide feedback related to recovery-oriented practice.



The [Certified Psychosocial Rehabilitation Recovery Practitioner](#) training from PSR Canada provides practitioners with education on recovery-oriented practice.



The [Team Recovery Implementation Plan](#), by ImROC, provides an assessment tool and action plan to help teams implement recovery-oriented practice in their unique contexts.





Employee engagement

Here are some strategies you can use to get your staff engaged:

- Use advisory boards and workgroups to enhance recovery-oriented practice.
- Provide resources and supports to enable people to put recovery-oriented approaches into practice.
- Partner employees and service users together in co-design projects to improve services and programs.
- Remove barriers that hinder people from putting recovery-oriented approaches into practice.
- Create opportunities for reward and recognition for recovery-oriented practice.
- Identify recovery-oriented practice champions throughout your organization.
- Share stories from service users and practitioners about the positive impacts of recovery-oriented practice.



The [Making of the 2016-2017 \[Ontario Shores\] Annual Report](#) is co-produced by patients and staff, working as partners through the editorial, design, and publishing process.



Ontario Shores' [Recovery Art Showcase](#) celebrates recovery through the efforts and talents of those with lived and living experience of mental health problems and illnesses.



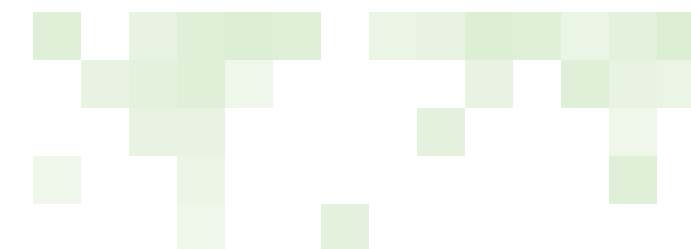
Ontario Shores' annual [Dr. Ian Dawe Recovery Award](#) recognizes and rewards clinical and non-clinical staff who support recovery approaches, with nominations submitted by people with lived and living experience of mental health problems and illnesses.



Section 4: Applying the principles

What does it look like when the principles of implementation science are put into effect? This section explores in detail the way implementation might flow within three different kinds of organizations. It provides:

- ideas for using the [Guidelines](#) in different contexts
- examples of progression through the four phases
- tools, resources, and templates designed to support recovery-oriented practice.



Three types of organizations

Each type of organization provided as an example in this section has its own unique needs and profile:

Mental health hospital

A publicly funded hospital with more than 1,000 employees and more than 300 beds, offering both inpatient and outpatient programs

Community mental health service

A not-for-profit agency with more than 200 employees providing community mental health services to people and families with lived or living experience of mental health problems or illnesses

Mental health network

A network of 12 community partners working together to provide individuals and families with options to support their mental health

Example 1: Mental health hospital

A publicly funded hospital with more than 1,000 employees and more than 300 beds, offering both inpatient and outpatient programs

The mental health hospital has been on a multi-year journey to improve and sustain recovery-oriented practice in its inpatient and outpatient programs. Its journey began when the board of directors approved the organization's new recovery-focused mission, vision, and core values.

For many years, the hospital has used an annual action planning process to identify the specific strategies it will undertake each year to improve recovery-oriented practice. The board of directors schedules regular check-ins with all departments to get updates about how the recovery action plan is progressing and making a positive difference for the hospital's service users.

Phase 1: Engage and explore

Each year, the recovery action planning process starts with an assessment of the organization's current state of recovery-oriented practice.

The assessment could include any or all of the following:

- hiring a recovery expert to conduct an organizational review using the [Guidelines for Recovery-Oriented Practice](#)
- using an organizational assessment tool such as the [Recovery Promotion Fidelity Scale](#) or [Sustainability Model](#) customized to assess the Guidelines
- analyzing internal data to see what outcomes have been and have yet to be achieved

The results of the assessment are shared with the executive leadership team, along with recommendations to improve recovery. Based on those recommendations, the executive leadership team sets

goals for the recovery action plan related to one or more of the six dimensions of recovery practice.

A team is then formed to develop an action plan, including people from

- executive leadership
- management
- advisory groups of people with lived and living experience of mental health problems or illnesses and/or substance use
- research and academics
- professional practice
- peer support
- quality and patient experience
- organizational development and learning
- communications
- project management
- advanced practice nursing.

The recovery action plan team

- chooses the strategies that will be used to meet the goals
- selects metrics to measure recovery and action plan outcomes (see Phase 2: Plan and prepare and Phase 4: Sustain and scale)
- brainstorms any risks or competing priorities that may prevent them from achieving the goals
- makes suggestions to address any risks or competing priorities that arise.

Once the action plan is fully developed, the team presents it to the executive leadership team along with a request for required resources. The executive leadership approves the action plan and schedules monthly progress updates. The action plan is shared with the entire management team, including executive

leaders, directors, and managers, at the hospital's annual leadership retreat.

Phase 2: Plan and prepare

The recovery action plan team chooses strategies to improve recovery-oriented practice based on the goals outlined in the plan. The example below shows the strategies selected to achieve a goal under the first dimension of recovery-oriented practice:

Goal

Dimension 1: *Creating a culture and language of hope*

Goal: Provide the opportunity for people to express their goals and self-direct their care to help build hope

Strategies

- Conduct focus groups and interviews with service users to assess opportunities to further involve them in their care plans.
- Enhance electronic medical records to include a section called [Recovery Story](#), where a service user's interests, goals, and hopes can be documented.
- Train practitioners on how to use guiding questions with service users to populate the Recovery Story section in their medical records.
- Audit service user charts and provide feedback to practitioners about their use of the Recovery Story.
- Recruit service users to co-facilitate courses in the hospital's [Recovery College](#) based on their goals and interests.

Example 1: Mental health hospital continued

The hospital uses the [RE-AIM framework](#)⁸ to develop metrics and link expected positive outcomes to the action plan’s strategies, allowing it to assess whether the changes brought about by the action plan will be long-lasting.

The RE-AIM framework looks at expected positive outcomes related to five areas:

- **Reach:** The number of practitioners with the skills, knowledge and willingness to participate in recovery-oriented practice
- **Effectiveness:** The benefits (or positive service user outcomes) to people with lived and living experience of mental health problems or illnesses and/or substance use
- **Adoption:** The level to which practitioners use the six dimensions of recovery in their daily practice
- **Implementation:** The level to which recovery-oriented practice was put into action as intended according to the action plan and the [Guidelines](#)
- **Maintenance:** The level to which the six dimensions of recovery are integrated and ongoing among the practices and operations of an organization

The following example shows how the hospital used the RE-AIM framework to align expected outcomes with its goals, its strategies, and the six dimensions of recovery-oriented practice:

Goals

Dimension 1: *Creating a culture and language of hope*

Goal: Provide the opportunity for people to express their goals and self-direct their care to help build hope

Positive outcomes

- Number of focus groups and interviews conducted with service users to assess opportunities to further involve them in their care plan (**Reach**)
- New Recovery Story section added to the hospital’s electronic medical records (**Implementation**)
- Number of practitioners trained to use guiding questions with service users to populate the Recovery Story (**Reach**)
- Percentage of service user charts in which the Recovery Story section is populated and reviewed regularly by practitioners (**Adoption**)
- Number of service users recruited to co-facilitate courses in the hospital’s [Recovery College](#) (**Reach**)

Phase 3: Initiate and refine

Once the hospital starts putting its selected strategies into action, it also starts a Plan, Do, Study, Act (PDSA) cycle.

Figure 3: The Plan, Do, Study, Act cycle

Act:

- Put the suggestions to improve the change into action
- Roll out the plan for change with another group
- Start a new PDSA cycle

Plan:

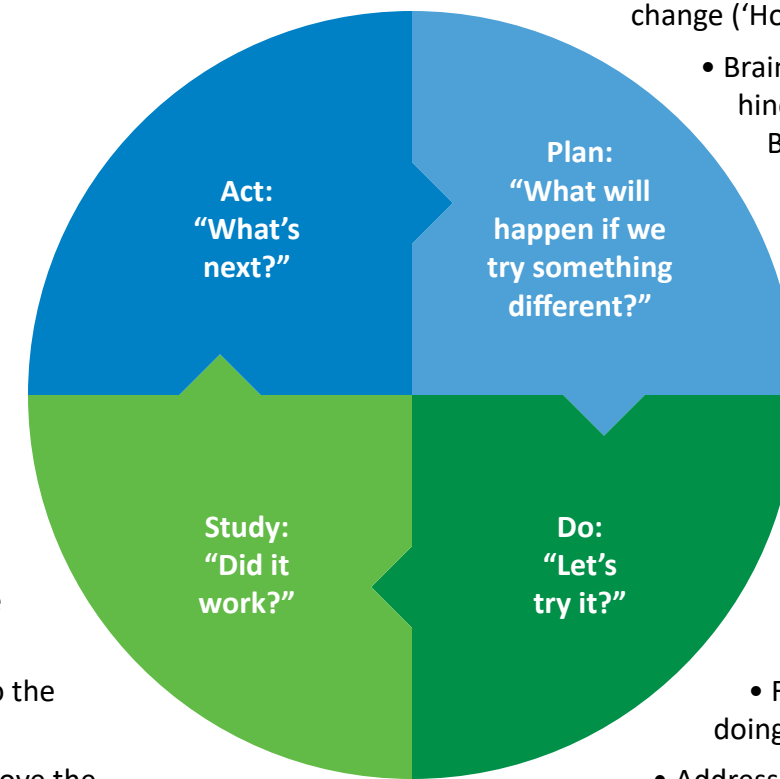
- Ask critical questions about the plan for change
- Create a plan to put the change into action
- Identify the objective and purpose of the change ('What')
 - Organize the strategies used to make the change ('How')
 - Brainstorm what will help and hinder the change ('Enablers and Barriers')
 - Predict what will happen if the change is a success ('Positive Outcomes')

Study:

- Analyze the data from the metrics
- Compare the outcomes to the predictions
- Make suggestions to improve the change based on the outcomes

Do:

- Put the plan for change into action
- Find out what works and keep doing it ('Enablers')
- Address problems with the change ('Barriers')
- Monitor metrics ('Positive Outcomes')



⁸ Glasgow, R. E., Vogt, T. M., & Boles, S. M., & Vogt, T. (1999). Evaluating the public health impact of health promotion interventions: The RE-AIM framework. *American Journal of Public Health, 89*(9), 1322-1327. <https://doi.org/10.2105/AJPH.89.9.1322>

Example 1: Mental health hospital continued

The introduction of the Recovery Story section to the hospital’s electronic medical records offers an example of the cycle in action. A few months after the new section was introduced, a chart audit found that the section was filled out in less than 20 per cent of the medical records, and that it was viewed regularly even less frequently.

By not filling out and reviewing this section, practitioners were left without insights into service users’ goals, interests, relationships, and hopes. This created a barrier to communicating positive expectations and promoting hope through self-directed care.

To address the barrier, the recovery action plan team hosted focus groups with practitioners to learn why

they weren’t using the section. Practitioners shared suggestions for improving uptake, including moving it to a more visible location in the record, making it a mandatory field, adding reminders to review, and maintaining a list of potentially relevant programs and services.

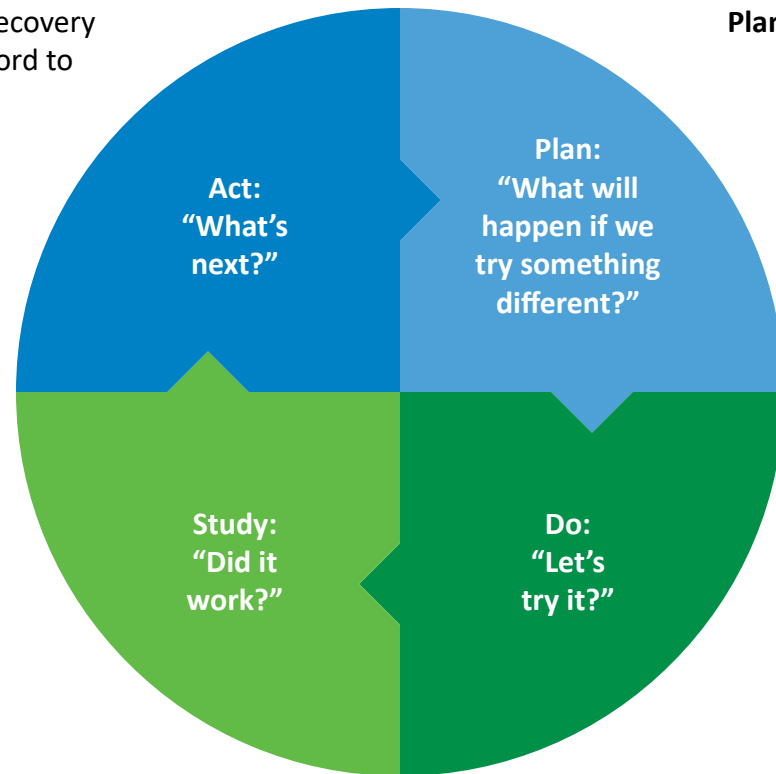
After implementing these suggestions, the team conducted another chart audit, this time finding completed Recovery Story sections in more than 80 per cent of medical records. More practitioners also reported using the section regularly to partner with service users in setting and working toward their recovery goals.

Figure 4 shows how the hospital used the PDSA cycle to achieve the outcome it was looking for:

Figure 4: The PDSA cycle in action at the mental health hospital

Act: Changes are made to the Recovery Story section of the medical record to improve its use.

Study: A chart audit finds that the new section is not being used. Focus groups are held to find out why not.



Plan: Introduce a new Recovery Story section to the medical records.

Do: Practitioners start using the new section to partner with service users on their recovery goals.

Phase 4: Sustain and scale

Throughout the PDSA cycle, plan outcomes are monitored regularly. Typically, the team will start with a baseline metric, then identify target metrics to aim for.

When an outcome is achieved and associated metrics perform well consistently, the team knows the strategies were effective and can be replicated in new areas of the hospital.

If a metric is not achieved or performs poorly during the PDSA cycle, the team might include the goal again in the following year’s recovery action plan, try new strategies to reach the goal, or reassess the goal.

When the year’s action plan is complete, the team re-assesses the status of recovery-oriented practice throughout the organization. This marks the beginning of a new action planning process with new goals for improving recovery.

General reflection questions

- How do you engage people early in setting personal recovery goals and help people monitor progress toward their goals?
- How have you sought to understand what factors support recovery and to learn from those you serve?
- Do you use recovery and well-being planning tools that have been developed and validated through meaningful consultations with people with lived and living experience of mental health problems or illnesses and/or substance use?
- How does your documentation reflect your service users’ aspirations and goals?

Reflection questions for leadership

- How do leaders model and provide feedback to reinforce recovery-oriented behaviours and language in service planning, coordination, and review processes?
- How are leaders visible and active participants in celebrating achievement, growth, and progress toward recovery goals?
- To what extent can the systems and processes in your setting (e.g., intake, documentation, family involvement) offer flexible and individualized approaches?

Goals

Dimension 1: Creating a culture and language of hope

Goal: Provide the opportunity for people to express their goals and self-direct their care to help build hope

Positive outcomes

- Percentage of service user charts in which the Recovery Story section is populated and reviewed regularly by practitioners (**Adoption**)

Metrics Baseline

- 20% completed
- 16% viewed more than once

Metrics Target

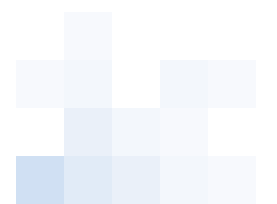
- 85% completed
- 100% viewed more than once



The Recovery-Oriented Practice Action Plan Template is available on [page 47](#).



The [Recovery-Oriented Practice Action Plan Sample](#).



Example 2: Community mental health service

A not-for-profit agency with more than 200 employees providing community mental health services to people and families with lived or living experience of mental health problems or illnesses

The community mental health service started by assessing its current state of recovery-oriented practice using the [Sustainability Model](#), customized based on the [Guidelines](#). Results showed that improving access to recovery training and education for staff and peer support workers would help them feel confident and competent to use recovery-oriented practice. The organization saw the [Guidelines](#) as a tool to identify the attitudes, knowledge, and skills in which employees could be trained.

Phase 1: Engage and explore

The organization had few resources available for developing training and education, so a member of the senior leadership team took the lead exploring best practices for recovery training and education. Co-production was shown to be the best approach.

Co-production engages people with lived and living experience of mental health problems or illnesses and/or substance use as equal partners to identify opportunities and create solutions to improve health-care services.



[Co-Production – Sharing Our Experiences, Reflecting on Our Learning](#): A briefing from ImROC



[Co-production in mental health](#): A literature review commissioned by Mind

The organization put together a recovery training and education project team, including

- peer support workers
- people with lived and living experience of mental health problems or illnesses and/or substance use
- carers and family members of people with lived and living experience
- communications and training coordinators
- nursing staff
- mental health workers.

The project team wanted better insight into what the staff did and didn't already know about the six dimensions of recovery. They conducted focus groups and interviews with staff from a variety of roles across the organization, using the reflective practice questions in the [Guidelines](#). The results showed staff would benefit from training and education on recovery-oriented practice.

They needed training to develop the skills and behaviours that would enable them to put recovery-oriented practice into action. They also needed education to develop values, attitudes, and knowledge about the differences between personal recovery and clinical recovery.

The project team then reached out to recovery leaders across the country for recommendations and information about recovery training and education that already existed.

Phase 2: Plan and prepare

After exploring options and best practices for recovery training and education for its staff and peer support workers, the project team developed an action plan with two goals. For each goal, the team chose training and education strategies to put their plan into action.

Goal

Adopt existing training programs proven to develop skills and behaviours related to recovery-oriented practice

Strategies

- Organize recovery training programs for staff and peer support workers.
- Use a train-the-trainer approach by certifying staff and peer support workers to be facilitators of the training programs.
- Create an annual training schedule to ensure ongoing training related to recovery-oriented practice.

Goal

Co-produce education to develop a deeper value and understanding of recovery principles among staff

Strategies

- Co-produce education about the principles of recovery using the [CHIME framework](#) and the six dimensions of recovery.
- Engage people with lived and living experience, and their families and friends, to be co-facilitators of the education program.
- Create an annual schedule to ensure ongoing education related to recovery.
- Distribute educational materials, job aids, and artefacts about recovery-oriented practice to staff and peer support workers.
- Create a community of practice with staff and peer support workers for recovery-oriented practice.

Before starting its action plan, the project team mapped the skills from the six dimensions of recovery to each training program they planned to offer. This mapping exercise helped the organization track how the various training programs would help staff develop their skills in recovery-oriented practice.

Example 2: Community mental health service continued

Phase 3: Initiate and refine

The organization scheduled education days for staff and peer support workers throughout the year to enable full participation in recovery training programs. After each session, participants were asked to provide feedback. Many said they appreciated being given education days to focus on developing their skills, so the project team noted education days as enablers of program success.

Participants also said that programs facilitated by peer support workers were especially effective. This feedback supported the research the project team had conducted at the start of the action plan, which showed co-production to be a best practice for recovery education and training.

The post-training feedback forms also helped identify barriers. Participants said they wanted more support to put the skills they were learning into practice after the education days. In response, the project team revisited the strategies in the action plan to look for ways to better support staff and peer support workers outside of scheduled education days.

One idea that came up was job shadowing. The team identified staff and peer support workers throughout the organization who had advanced skills in recovery-oriented practice, then scheduled times for other staff members and peer support workers to shadow them in meetings with service users. This approach gave novice practitioners the opportunity to ask questions about recovery-oriented practice and see it in action. Other times, staff members and peer support workers put their new skills into practice with service users and were shadowed by those with advanced skills in recovery. This approach allowed those with advanced skills to provide feedback to help novice practitioners improve their recovery-oriented practice.

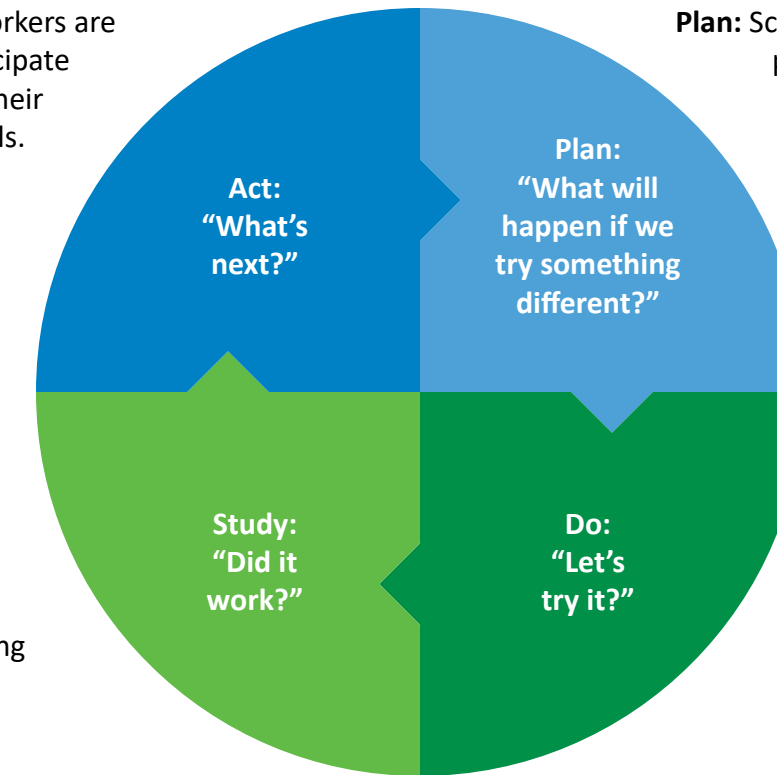
After the job shadowing program was implemented, staff members started reporting a significant increase in their use of skills related to all six dimensions of recovery.

Figure 5 shows how the community mental health service used the PDSA cycle to improve its training and education program.

Figure 5: The PDSA cycle in action at the community mental health service

Act: Staff and peer support workers are given the opportunity to participate in job shadowing to improve their recovery-oriented practice skills.

Plan: Schedule education days for staff and peer support workers to participate in recovery training programs to develop their skills.



Study: Post-training feedback shows staff members and peer support workers learned new skills during the training but wanted more support for practising those skills and seeing them put into action.

Do: Staff members and peer support workers participate in the training programs and learn new skills in recovery-oriented practice.

Example 2: Community mental health service continued

Phase 4: Sustain and scale

The project team used the [RE-AIM framework](#) to link expected positive outcomes to its goals and strategies. The team monitored these outcomes throughout the action plan and at the end of each training or education program.

Goal

Adopt existing training programs proven to develop skills and behaviours related to recovery-oriented practice

Positive outcomes

- Number of recovery training programs offered on an ongoing basis within one year (**Maintenance**)
- Number of participants in each recovery training program (**Reach**)
- Pre-training to post-training increase in participants' self-reported skills within each dimension of recovery (**Effectiveness**)
- Number of recovery training programs adopted (**Implementation**)
- Number of staff members and peer support workers who participate in job shadowing opportunities (**Adoption**)

Goal

Co-produce education to develop a deeper value and understanding of recovery principles among staff

Positive outcomes

- Number of service users, family members, and friends who participate as co-facilitators of the education program (**Reach**)
- Pre-education to post-education increase in participants' self-reported attitude toward and knowledge of recovery principles (**Effectiveness**)
- Number of recovery community of practice meetings per year (**Maintenance**)

The project team oversaw the action plan, training programs, and job shadowing opportunities for one full year. The project concluded once positive outcomes were being achieved consistently. At that point, the training and education annual schedule and programs became a part of the organization's regular operations overseen by the communications and training department.

General reflection questions

- How have you built partnerships with peer support workers and supported local peer leaders in community initiatives?
- How have you shared information, research, and resources to help embed recovery-oriented principles and practices in your organization?
- How have you combined experiential knowledge and professional expertise to create a collaborative body of knowledge and foster the co-creation of programming?

Reflection questions for leadership

- How have you drawn on lived and living experience and encouraged the co-production of policies, procedures, education, and training?
- What opportunities have you built for people with lived and living experience of mental illnesses/problems or substance use to be collaboratively involved in service change, practice enhancement, and professional development?
- How do you encourage workplaces that are safe, healthy, supportive, nurturing, and recovery-enhancing?
- How have you integrated peer support workers and others with lived and living experience within your service setting? Consider your organization's position statements, professional development opportunities, approach to funding, and management supports.



The Recovery-Oriented Practice Action Plan Template is available on [page 47](#).



The [Recovery-Oriented Practice Action Plan Sample](#).

Example 3: Mental health network

A network of 12 community partners working together to provide individuals and families with options to support their mental health

The mental health network decided to start a [Recovery College](#) together as a way to provide mental health support. Recovery Colleges offer non-formal courses about mental health and recovery for people with lived and living experience of mental health problems or illnesses and/or substance use. These courses are co-created and co-facilitated by experienced educators and people with lived and living experience. They are intended to improve participants' knowledge and skills, boosting their confidence to self-manage their mental health and well-being.

Phase 1: Engage and explore

Recovery College courses are designed and facilitated by educators and peer support workers from the partners in the network. The Recovery College uses the [Guidelines](#) to measure how well facilitators use recovery-oriented practice to develop and deliver their courses. The Guidelines are also used as a framework for participants to choose and develop their own courses.

At the end of each course, participants complete evaluation forms that rate the level to which the six dimensions of recovery were included in the course and modelled by the facilitator. Course facilitators use this evaluation data to create their own learning and development plans to help them improve their course content and how they deliver it.

Each plan starts with goals related to the dimensions and skills in recovery-oriented practice they want to improve:

Dimension to work on

2D: Building collaborative relationships and reflective practice

Skills to improve

- Share ideas and options with a coaching approach, rather than giving advice in a critical or judgmental way.
- Encourage open and honest discussion, especially when there are differences.

Goals

I will advance my skills in building collaborative relationships and reflective practice by

- improving my coaching skills to avoid advice-giving behaviour
- enhancing my facilitation skills to ask questions that promote open and honest discussion among course participants.

Phase 2: Plan and prepare

After they have identified their goals, facilitators choose the strategies they will use to achieve them:

- Attend Recovery College courses taught by recovery-oriented champions to observe how they facilitate and ask questions to promote discussion.
- Join the Recovery College community of practice to learn from the experiences and best practices of other facilitators.
- Enrol in a course on coaching for development.
- Plan regular time in the course for open and honest discussion among participants about the course content and their experiences.
- Attend a co-production event to help develop a Recovery College course.

Phase 3: Initiate and refine

Facilitators submit their learning and development plans to their supervisors as part of their performance development cycles. As they put their individual learning and development plans into action, they meet regularly with their supervisors throughout the year to provide progress updates:

- September: Have had success in leaving time in the course for participants to have open and honest discussion about the course and their experiences.
- October: Sat in on the Leisure, Health, and Wellness course and learned an excellent question to start a discussion with participants: "What is on your mind today?"
- November: Did some research on coaching courses. Found a three-day certification course. Does the organization have funds to cover course fees?

As much as possible, supervisors should try to remove barriers that could interfere with course facilitators' skills development, such as the course fees mentioned in the example above. In response, the supervisor submitted a proposal to the mental health network suggesting that each partner contribute funds to cover the cost of hosting a coaching course locally, allowing each organization to send two to three participants to the course. The proposal was accepted and overcame a key funding barrier to skills development. The proposal also served as an enabler, helping many facilitators receive training and enhance their skills in recovery-oriented practice.

Figure 6 shows how the mental health network used the PDSA cycle to support the skills development of its Recovery College course facilitators.

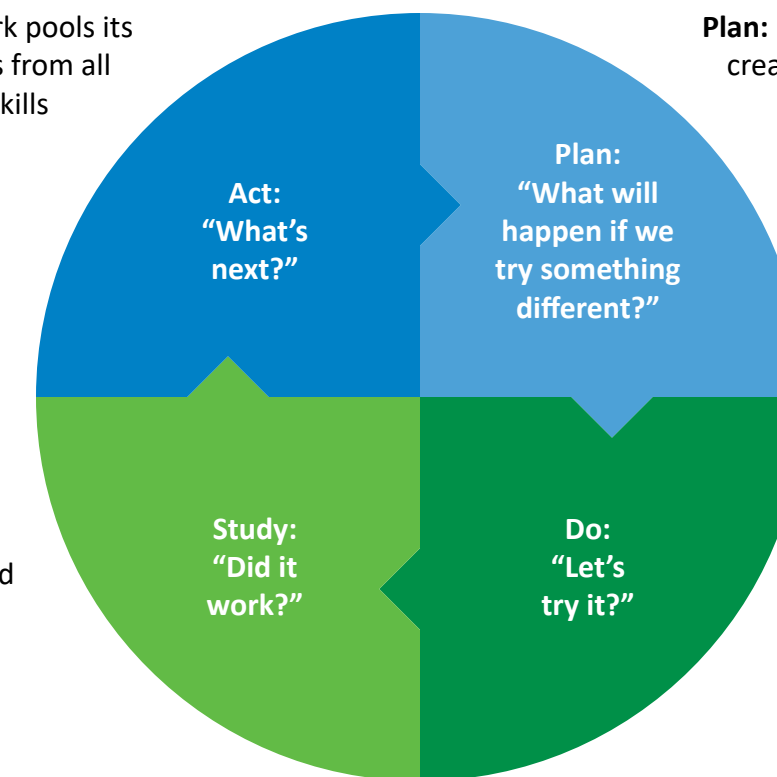
Figure 6: The PDSA cycle in action at the mental health network

Act: The mental health network pools its resources to enable facilitators from all partner organizations to take skills development courses.

Plan: Recovery College course facilitators create learning and development plans to improve their skills.

Study: During a regular learning and development plan update, a supervisor observes that funds are needed to send facilitators to skills development courses.

Do: Recovery College course facilitators use the strategies in their plans to improve their skills.





Example 3: Mental health network continued

Phase 4: Sustain and scale

At the end of the next Recovery College semester, courses and facilitators are again evaluated by participants. Facilitators' learning and development plans are updated with the latest results from the evaluation forms, showing the level to which they have improved in their ability to design and deliver Recovery College courses:

- 32% increase in participants' positive response to the indicator, "The facilitator shared ideas and options with a coaching approach."
- 58% increase in participants' positive response to the indicator, "The facilitator encouraged open and honest discussion, especially when there were differences."

When the learning and development plan cycle concludes at the end of each program year, facilitators start a new cycle by choosing other skills to develop from the [Guidelines](#) based on their most recent course evaluations. The annual cycle ensures that recovery-oriented practice is sustained and advanced by the organizations in the mental health network.

General reflection questions

- How have you built partnerships with peer workers and supported local peer leaders in community initiatives?
- What evidence shows that partnership and community collaboration is "core business" for recovery and not a discretionary extra?
- How do you routinely and systematically draw on the strengths, knowledge, expertise, and resources of other services to support and enhance the achievement of recovery goals?
- How have you learned from the wisdom and experience of others in the areas of supervision, mentoring, and coaching?

Reflection questions for leadership

- How have you supported peer-led community partnerships and community coalition initiatives?
- How do you collaborate across organizations to facilitate access to services and reduce barriers in information sharing and assessment across services?
- Do your position statements, service agreements, and contracts include a commitment to proficiency in recovery-oriented practice and service delivery?
- How do you access experiential knowledge to establish supportive, responsive, person-centred service partnerships?
- What mechanisms have you used to work with others such as regulatory groups, funders, or community leaders to promote expanded opportunities for partnerships?
- How does your performance management system assess progress made by staff members in supporting recovery?



The Recovery-Oriented Practice Action Plan Template is available on [page 47](#).



The [Recovery-Oriented Practice Action Plan Sample](#).



Section 5: Real-world perspectives

We reached out to organizations across Canada to learn more about their experiences implementing recovery-oriented practice and the Guidelines. Their stories shed light on the wide variety of ways recovery principles can be adopted and applied. Featured organizations include:

- [Association québécoise pour la réadaptation psychosociale](#)
- [Consumers' Health Awareness Network Newfoundland and Labrador](#)
- [Canadian Mental Health Association – Calgary \(Alberta\)](#)
- [Foundry \(British Columbia\)](#)
- [Ontario Shores Centre for Mental Health Sciences](#)
- [Peer Connections Manitoba](#)
- [Phoenix Residential Society \(Saskatchewan\)](#)
- [Reach Out Centre for Kids \(Ontario\)](#)





Creating full-fledged citizens Implementing recovery-oriented practice: AQRP

Twenty-five years ago, the Association québécoise pour la réadaptation psychosociale (AQRP) was already talking about the importance of establishing a personal recovery-oriented health system and drawing from the experiences of people living with mental health problems, including those we refer to today as peer support workers. To demonstrate that these individuals can contribute to society and reach their full potential despite a mental health diagnosis, the AQRP has aligned its approach with the perspectives set out in the Guidelines.

From its inception in 1990, the AQRP has advocated for the empowerment of people with lived or living experience of a mental health problem, believing that they must be able to live and thrive as full-fledged citizens if they are to be fully integrated into the community. The AQRP encourages housing support and access to work or study initiatives, provided that the emphasis is on people as key actors in their own lives, not simply as beneficiaries of assistance services.

The AQRP has always served as an information hub, bringing together stakeholders from all mental health intervention sectors, public and community organizations, and people with lived or living experience and their personal networks.

Knowledge transfer is one of the AQRP's key intervention initiatives. Its biannual colloquium brings together 500 to 1,200 stakeholders from all disciplines, including those with lived or living experience and members of their personal organizations. For close to 30 years, the AQRP has also published *Le Partenaire*, a journal that disseminates best practices in psychosocial rehabilitation and brings together scientific and experiential knowledge to encourage recovery-oriented services, in Quebec and beyond, for managers, professionals, and citizens at large.

“One of the AQRP's strengths has always been its promotion of integrated knowledge — that is, knowledge that places theory, science, and experience on an equal footing,” says Diane Harvey, executive director of the AQRP.

AQRP
Quebec City

What they do:

Serve as a hub for mental health information and action

Key recovery-oriented programs:

- Training on recovery
- Support and access to work and studies
- Biannual multidisciplinary colloquium
- Peer support worker programs
- Anti-stigma initiatives

Implementation insights:

- To promote full citizenship
- To acknowledge and promote experiential knowledge
- To encourage contact-based strategies

“One of the AQRP's strengths has always been its promotion of integrated knowledge — that is, knowledge that places theory, science, and experience on an equal footing.”

– Diane Harvey, AQRP Executive Director

Challenges: The harmful effects of stigmatization on recovery

Despite the importance of knowledge transfer in promoting the experiential knowledge of people with lived or living experience of a mental health problem, that alone is not enough to change stigmatizing attitudes regarding mental health. According to the World Health Organization, one person in four will experience a mental health problem in their lifetime, and nearly two-thirds of these individuals will not seek help for fear of prejudice. In fact, some report that they suffer more from stigmatization than from the condition itself.

“Making it possible for people living with mental health problems to enjoy full citizenship means that we're doing more than simply reducing their symptoms,” says Harvey. “We all have the right to a fulfilling life, a life that's worth living. We must put in place the conditions needed for people to be hopeful. And stigmatization is a barrier to hope.”

Laurence Caron, project manager and trainer in the Pairs Aidants Réseau (Peer Support Network) and *Lutte contre la stigmatisation* (Combating Stigmatization) programs, adds that, “Promoting full citizenship for all isn't a question of services; it's about culture and society. And it's not about saying, ‘Let's hire someone who is sick,’ for example, but rather ‘Let's hire potential,’ and believing it.”

Through its experience, the AQRP has observed that change is needed within health-care establishments themselves, where people's lived experience, whether that of users or health-care staff, is still seen (all too often) as a weakness rather than an asset.

Solutions: A contact strategy that promotes experiential knowledge

The AQRP works to combat stigmatization through direct personal contact with diverse positive recovery models. It supports social inclusion and empowerment, but above all, it gives opportunities to people who want to be at the heart of social changes they would

like to see. It recommends the following strategies:

- Coming together through a “contact strategy.” Studies show that positive human encounters are more effective than information alone in reducing prejudices, educating, giving hope, improving behaviours and attitudes, and creating better relationships in our communities. On this basis, the AQRP employs a contact strategy, recognized for creating positive interactions between the members of a stigmatized group and a specific segment of the public.
- Recognizing ourselves in those who are helping us and envisaging a different future. The publicly funded Pairs Aidants Réseau training program, established in 2006, is based on the contact strategy and integrated knowledge. This specialized training normalizes the practice of peer intervention and provides tools for people in recovery that enable them to use their lived experience and human relations skills to support others in recovery. Peer support workers are part of a multidisciplinary team within a health institution and are paid for their work.

“More and more teams, health institutions, and community organizations are recognizing the precious role that can be played by people who have recovered or are recovering — peer support workers, mutual support groups, patient partners, and integrated knowledge trainers — and what they can contribute to managers, health professionals, and researchers based on their experiential knowledge,” says Caron. “Having positive experiences with people who have lived with or are living with a mental illness leads to a sincere belief in recovery. It offers a glimmer of hope that we will stop viewing these people as ‘a total loss, as the vanquished’ and see them as ‘people, citizens, the victors,’ with strengths and potential.”

- Helping to turn a page. In 2018, the AQRP joined forces with the Association des bibliothèques publiques du Québec to launch the initiative *À livres ouverts* (Open Books). Inspired by the Living Library project, it replaces the books used in a classic library with people who are experiencing or have been directly affected by a mental health problem — so they become “living books.”

Living library users choose the meetings they would like to attend. During informal, 15- to 20-minute conversations, these living books share a chapter of their lives, and their hopes, one person at a time.

Key dates in the AQRP's recovery-oriented practices:

1990: Creation of the AQRP

2000: The AQRP's orientation document guides the creation of the Comité national santé mentale travail (CNSMT)

2004: Establishment of the first training committee on psychosocial rehabilitation and recovery

2006: Launch of the Pairs Aidants Réseau program

2007: Development of the recovery and full citizenship program, including a component on the need for service transformation

2010: Creation of the Groupe provincial d'experts sur l'intégration au travail en santé mentale, in collaboration with the Minister for Health and Social Services and the Employment and Social Solidarity, as well as the Groupe provincial de lutte contre la stigmatisation et la discrimination en santé mentale

2014: Development of a reference framework on the fight against stigmatization and a provincial training tour on the best anti-stigma strategies

2018: Launch of the Semaine des bibliothèques vivantes : À livres ouverts

Results: The exponential impact of the contact strategy

The first edition of the À livres ouverts event was a huge success, and it has become a key aspect of the fight against stigmatization and the promotion of social inclusion in Quebec. In 2019, the event took place in libraries across 13 regions, in 31 towns and cities, with over 2,200 testimonials. (Due to the pandemic, the 2020 edition had to be postponed.)

Rafaëlle Marianne became one of the living books in 2019 and fully intends to participate in the next edition. "It's an incredible contact strategy, really innovative," she says. "Contact transforms perspectives, judgments, and behaviours toward people who have experienced a mental health problem."

In addition to being a living book, Rafaëlle received her certification as a peer support worker in 2019. She does not hold back her praise for the training offered by the AQRP. "The program changed my life. It's proven to be beneficial for everyone. It's simulating [and] empowering and promotes self-esteem," she says.

As a peer support worker, Rafaëlle was trained to listen and was given the tools to help her peers. "People tell you what they need when they're listened to," she says. Today, she is paid to support people and members of their personal networks, offer internships in health-care settings, participate in research projects, and speak at events.

"Having positive experiences with people who have lived with or are living with a mental illness leads to a sincere belief in recovery."

– Laurence Caron, AQRP Project Manager and Trainer

"People tell you what they need when they're listened to."

– Rafaëlle Marianne, peer support worker trained by the AQRP

Next Steps: Drawing greater benefits from experiential knowledge

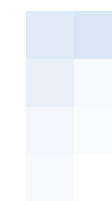
The AQRP will continue to promote the power of experiential knowledge. "The health network officially recognized the added value of experiential knowledge and peer support workers in its last two five-year action plans," says Caron. "There's still a lot of training and information dissemination to do because the shift to recovery-oriented services is a major undertaking and cannot be shouldered by just a few peer support workers." For people with lived or living experience of a mental health problem, the support provided by peer support workers gives them hope and instils in them the belief that a better future is possible. It also leads to a greater sense of independence and empowers people to take action. "This is one of the keys to attaining full citizenship," says Harvey.



To learn more about the AQRP and its programs, go to aqrp-sm.org.



For a full list of the skills, behaviours, values, attitudes, and knowledge required to implement all six dimensions, see the complete [Guidelines](#).



How the AQRP's approach supports the dimensions of recovery-oriented practice



Dimension 1: Creating a culture and language of hope

The training hub, including the peer support network program, uses integrated knowledge to promote change, thereby enabling both the people being helped and the managers and teams to believe in a better future.



Dimension 2: Recovery is personal

Through its promotion of best practices in psychosocial rehabilitation and its various programs, and by placing people who have experiential knowledge in the driver's seat of these programs, the AQRP promotes recognition of the self-determination of people in recovery.



Dimension 3: Recovery occurs in the context of one's life

By promoting full citizenship for all and combating stigmatization through its training program, its provincial frame of reference, and the À livres ouverts program, the AQRP seeks to ensure that recovery can occur in the context of one's life.



Dimension 6: Recovery is about transforming services and systems

Transforming services and systems is essential to making a real shift toward recovery-oriented practices, in addition to ensuring that the organization's vision, mission, and values, including hiring practices, are aligned with recovery-oriented practices. The AQRP's peer support network program is a good example of service transformation because it trains peer support workers to act as liaisons between the mental health services system and service users in order to improve service delivery and understand everyone's needs.



Finding the right words Implementing recovery-oriented practice: CHANNAL

CHANNAL (Consumers' Health Awareness Network Newfoundland and Labrador) has always focused on recovery, but the publication of the MHCC's Guidelines in 2015 gave it the language to fully explain its approach — along with the evidence base and support of a national organization to expand its services and help shape provincial mental health policy.

Since 1989, CHANNAL has been run by and for people with mental health issues, encouraging recovery and self-determination by providing a safe space where people can support and learn from one another. Peer support, which is strongly aligned with the principles of recovery, is a key component of CHANNAL's service offering. But for its first 20 years, the organization's approach to peer support was quite informal, largely because there weren't any standards or guidelines to follow. That changed starting in 2010, when CHANNAL was invited to join the MHCC committee creating the Guidelines for the Practice and Training of Peer Support. A year later, it contributed to the Guidelines.

"The recovery guidelines reinforced what we've been doing since the beginning but never had the language to articulate," says Paula Corcoran, CHANNAL's executive director. "Having that body of evidence behind us has been critical in showing those who are skeptical how this kind of work should be done."

As the Guidelines were being developed, CHANNAL used its inside knowledge of the six dimensions to create a recovery-focused training program for Newfoundland and Labrador's Department of Health and Community Services. Led and owned by people with lived experience, the training program was released in 2013 and has since been delivered to all mental health and corrections staff across the province.

CHANNAL

St. John's, Newfoundland and Labrador

What they do:

Encourage recovery through programs run by and for people with lived and living experience of mental health and substance use issues

Key recovery-oriented programs:

- Peer support
- Public education
- Policy consultation

Implementation insights:

- Put people with lived experience at the heart of your organization.
- Invest in training.
- Give people choice in what their recovery looks like.

"The recovery guidelines reinforced what we've been doing since the beginning but never had the language to articulate."

— Paula Corcoran, Executive Director

Challenges: When partners have different perspectives

CHANNAL has always aimed to make allies wherever it could, working with governments, businesses, non-profits, and others to make peer support an integral part of Newfoundland and Labrador's health-care landscape. Today, the province is one of CHANNAL's biggest supporters. While that's a good thing, it also brings some risks. With the government currently providing 95 per cent of CHANNAL's funding, any change in allocations could have a severe impact on service delivery.

CHANNAL's close ties with the province have also caused some friction with the activist community, which can favour more direct approaches to mental health advocacy over diplomacy. The organization believes there's a time and place for both approaches, but the two sides must start working together.

The stigma associated with mental illness continues to present challenges as well. CHANNAL still encounters partners who "don't want to burden" its staff — all people with lived experience — with tasks such as writing proposals, doing research, or facilitating interviews. Making the case for equal participation with facts, rather than pulling at heartstrings, can be difficult.

Solutions: Advice to make recovery-oriented practice work

CHANNAL's peer support services are all informed by the Guidelines, including in-person support for individuals and groups, phone support, a drop-in safe space, wellness workshops, and more. In the organization's experience, when implementing recovery-oriented approaches, it's important to keep several things in mind:

- **Pace yourself.** CHANNAL's process of solidifying its approach to recovery has been underway for nearly 10 years — and will continue for many more to come. Because implementation is a marathon, not a sprint, Corcoran encourages organizations to go bit by bit, picking up easy wins by harvesting the "low-hanging fruit" first.
- **Put lived experience at the heart of your organization.** CHANNAL only hires people who publicly identify as living with a mental health condition — not just front-line peer support roles but managers and directors, too. "When we hire folks, we don't talk about what you can't do, but what you *can* do within the parameters of your condition," says Corcoran.
- **Invest in training.** Because CHANNAL employs people across a range of education levels and lived experience, formal training on being empathic and nonjudgmental ensures that its services are delivered reliably and consistently.
- **Give people choice in what their recovery looks like.** People need to shape their own recovery journeys. Rather than imposing a solution, introduce service users to all the resources and supports that are available, then ask them to choose from those options for themselves.
- **Diversify your revenue sources.** To lessen the impact of potential government funding cuts, CHANNAL is now expanding its for-cost training and consultation to the business community.

CHANNAL's recovery-oriented practice implementation journey:

1989: Creation as a peer support group under the Canadian Mental Health Association

2006: Divestment from CMHA to become its own non-profit entity

2010: Participation in development of the MHCC's *Guidelines for the Practice and Training of Peer Support*

2011: Launch of Newfoundland and Labrador's first standardized peer support training, aligned with the MHCC's Guidelines

2012: Participation in the development of the MHCC's Guidelines

2013: Launch of a recovery-oriented practice training program, in partnership with the provincial government

2017: CHANNAL's executive director appointed chair of the Provincial Recovery Council for Mental Health and Addictions

Results: Strong growth fuelled by a commitment to recovery

By aligning its approach with the dimensions of recovery, CHANNAL has strengthened its partnership with the provincial government. In 2017, the minister of Health and Community Services launched the Provincial Recovery Council for Mental Health and Addictions, naming Corcoran as its chair. Now CHANNAL advises the minister directly, ensuring that any new mental health programs and policies are designed through a recovery lens. And during the early days of COVID-19, the premier mentioned CHANNAL regularly during his daily updates — a clear indicator of its growing influence.

When Corcoran started in 2010, she was one of three staff members and the organization's budget was \$200,000. Today, CHANNAL has 40 staff and a budget approaching \$2 million, with service delivery growing 1,000 per cent between 2015 and 2020.

"Without question, that growth is directly linked to our commitment to people with lived experience and our ability to embody a recovery philosophy in everything we do," says Corcoran.

CHANNAL's users see that commitment each day. Troy, a singer/songwriter with schizophrenia, says everything he's done there is about his recovery, not his illness. From one-on-one support to Freestyle Fridays, where musicians get together to jam and support each other, he appreciates being able to share with others who can relate to his situation and can help him through good times and bad.

"It's been a breath of fresh air," says Troy. "A lot of people around me don't understand what I'm going through. I've seen counsellors, occupational therapists, family doctors. It's only at CHANNAL where I don't feel like a number or a victim."

"I've seen counsellors, occupational therapists, family doctors. It's only at CHANNAL where I don't feel like a number or a victim."

– Troy, CHANNAL service user

Next Steps: Inspiring success

As CHANNAL continues to grow, there's always a risk of moving too fast. But with the Guidelines at the ready, Corcoran is confident the organization will manage growth in a healthy way.

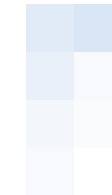
"Anything the MHCC releases gets incorporated into what we do," she says. "We'll always use their work as guidance and inspiration so we can continue help people with lived experience move beyond their symptoms and live the life they deserve."



To learn more about CHANNAL and its programs, visit channal.ca.



For a full list of the skills, behaviours, values, attitudes, and knowledge required to implement all six dimensions, see the complete [Guidelines](#).



How CHANNAL embodies the dimensions of recovery-oriented practice



Dimension 1: Creating a culture and language of hope

Because CHANNAL only employs people with lived experience — from peer supporters to its executive director — the principles of recovery are embedded in all its services and policies.



Dimension 2: Recovery is personal

Every person's recovery journey is different, so service users are introduced to all available resources and supports, then invited to choose which they'd be most comfortable trying at that time. Staff are also supported to create their own personalized recovery plans.



Dimension 3: Recovery occurs in the context of one's life

When working with partners, CHANNAL asks that people with lived experience participate in all project-related tasks as equals, not as "token" representatives.



Dimension 4: Responding to the diverse needs of everyone living in Canada

CHANNAL's client base includes youth, seniors, and all ages in between, with formal training to ensure its services are delivered consistently and in line with best practices.



Dimension 6: Recovery is about transforming services and systems

CHANNAL is making recovery an integral part of the mental health landscape by creating training programs for corrections workers and regional health authorities, influencing policy as part of the Provincial Recovery Council, and more.



Putting an international model to work at home Implementing recovery-oriented practice: CMHA Calgary

When faced with a sudden spike in demand for its services, CMHA Calgary didn't have time to build a new program from scratch. In the Recovery College model developed in the U.K., it found a solution that could be adapted quickly to the needs of Calgarians — informed by the MHCC's *Guidelines for Recovery-Oriented Practice*.

CMHA Calgary has been supporting Calgarians with mental health issues since 1955. Its shift to recovery-oriented practice began in 2013: when support calls spiked as people struggled with the trauma of seeing their homes damaged or destroyed by the city's biggest flood in 80 years, the organization decided to go “all in” on the recovery-based approach as a way to quickly respond to the community's needs.

“Our leaders were the catalysts driving this forward,” says Ashley Lamantia, program manager, Education and Support Programs at CMHA Calgary. “They saw this work happening across Canada and around the world and embraced it.”

Its largest recovery program is Recovery College, which offers more than 45 courses on a wide variety of mental health topics (e.g., coping with anxiety, harm reduction, setting boundaries, caregiver support) — all available for free to the public.

The organization adapted the U.K. model for the Calgary context by infusing it with data specific to the city and its service users. After studying the model's core best practices, the team bolstered its staff with recovery trainers and peer support workers, who then worked together to determine which topics would work best for Calgarians.

“We wanted the courses to be driven by the community, our clients, and our peer support workers, touching on things they wish they'd known or would be helpful in their recovery,” says Lamantia.

Courses aren't based on clinical diagnoses but instead focus on personal growth and recovery to help service users develop the skills and confidence needed to move forward in their lives. There are also

Canadian Mental Health Association – Calgary

What they do:

Promote mental health and wellness through community-based services for individuals, families, groups, and organizations.

Key recovery-oriented programs:

- Recovery College, which includes more than 45 free courses on mental health topics

Implementation insights:

- Remove physical barriers to your services.
- Co-create with people with lived and living experience.
- Stay flexible to give people what they need.

“We focus on what's
strong, not on
what's wrong.”

– Ashley Lamantia, Program
Manager,
Education and Support Programs

no prerequisites, meaning that anyone can take them in whatever order makes sense to them at the time.

While CMHA Calgary embedded the dimensions of recovery throughout all Recovery College courses, two in particular stand out to Lamantia: *Creating a culture and language of hope and Recovery is personal*. “We meet people where they are and focus on what's strong, not on what's wrong,” she says. “This empowers people and gives them choice within their recovery journey.”

Challenges: Creating a space as welcoming as the course content

Although Recovery College is free and open to all, CMHA Calgary found that its own environment wasn't as welcoming as it could be. When it launched the program, its office was on the fourth floor of a high-rise tower, forcing service users to pass through security and a receptionist before taking a course or meeting with a peer support worker. A new space was needed.

Also challenging was the fact that the recovery-based approach was not always well understood by the people who could benefit from it, necessitating a more concerted effort to educate and engage the public on why recovery matters.

Solutions: Adaptability and flexibility to always meet the community's needs

To address those challenges and make Recovery College as effective as possible, CMHA Calgary followed these best practices:

- **Do your research.** As it adapted the Recovery College model for success at home, CMHA Calgary relied heavily on local data and evidence to ensure that its programs addressed the voices and perspectives of its service users and reflected their goals, hopes, and needs.
- **Commit to co-creation and co-delivery.** All courses are co-created and co-facilitated by individuals with a background in social work or education as well as with peer support workers who have lived experience of mental health problems or illnesses and/or substance use.
- **Stay flexible.** Each course is adapted in the moment by the co-facilitators in response to the needs and group dynamic of the learners.
- **Eliminate barriers to access.** CMHA Calgary moved to a new location in 2018. Its offices are now located at ground level, with easy access to public transit. On the inside, a café-like environment creates a welcoming space where service users feel comfortable sharing their stories and can be connected to a peer support worker right away.
- **Raise community awareness of recovery.** The organization uses blogs and social media to raise Calgarians' awareness of recovery principles. It also ran a year-long podcast on the topic featuring interviews with mental health leaders and service users.
- **Roll with the punches.** CMHA Calgary hadn't planned to offer Recovery College online, but when COVID-19 hit, it had no choice but to end in-person programming. “We revamped course delivery completely,” says Lamantia. “But we had to make sure we were still following the Guidelines and best practices, while not getting too far away from our goal of having a welcoming space.”

CMHA Calgary's recovery-oriented practice implementation journey:

1955: Canadian Mental Health Association (CMHA) establishes a regional branch in Calgary

2013: Demand for mental health support surges after Calgary floods

2017: CMHA Calgary creates the Recovery College program

2018: CMHA Calgary moves to a new, more accessible location

2020: Recovery College goes virtual, available to people all over the world

“In the hospital, I felt very small and weak. At CMHA Calgary, I felt I reclaimed confidence and could show who I really was.”

– Rudeen, service user

Results: The “Netflix of mental health”

CMHA Calgary has seen a tremendous increase in Recovery College usage since moving to its new location. And the pandemic has generated unexpected benefits: while in-person courses were limited to people in Calgary, the online versions are available to a much broader audience, with learners logging in from across Canada and all over the world.

“Our hope is to create the Netflix of mental health,” says Lamantia, “to make it barrier-free and wait-list-free so people can access a course right away.”

For service user Rudeen, Recovery College has been a lifeline. While recuperating in a Calgary emergency department after her third suicide attempt, she listened to clinicians “scold” her for trying to take her own life and tell her why they thought she should want to live. She found the opposite experience at Recovery College, where the “raw reality” of hearing the stories of other service users helped her come to terms with her own.

“In the hospital, I felt very small and weak. At CMHA Calgary, I felt I reclaimed confidence and could show who I really was,” she says. “You actually feel part of a community and a sense of belonging among people with similar struggles. I didn’t feel so alienated and alone.”

Rudeen has taken every Recovery College course, which she says continue to help her along her journey. “Something you learned a few years ago can become real and alive. The seed takes root in your heart and you say, ‘I get it now.’” And after spending months on long-term disability, she has recently returned to work.

Former service users are giving back to the organization as well. Many return to volunteer or to help with fundraising. Others have become employees. “People tell us Recovery College is a place where they feel they could be at their best, and now they want to give back to others,” says Lamantia. “They believe in the cause and want to make a change in the community.”

While its shift to online delivery has proven successful, CMHA Calgary is preparing for the eventual return of in-person delivery. Plans are underway to deliver courses in group home settings, bringing recovery principles to even more people. The organization also welcomes collaborations with other organizations that want to start a Recovery College of their own.

Next Steps: Expanding impact while staying true to the Guidelines

As CMHA Calgary looks ahead, Lamantia says the focus will be on continuing to improve and revamp its existing courses based on community feedback.

“When people have a voice in how programming evolves, it gives them a sense of ownership and empowerment,” she says. “It’s nice to tap the shoulders of potential service users to make sure what you’re doing is in line with what they’re hoping for and that it balances their vision with the Guidelines and best practices.”



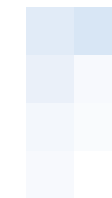
To learn more about CMHA Calgary, visit cmha.calgary.ab.ca.



To learn more about Recovery College, visit recoverycollegecalgary.ca.



For a full list of the skills, behaviours, values, attitudes, and knowledge required to implement all six dimensions, see the complete [Guidelines](#).



How CHANNAL embodies the dimensions of recovery-oriented practice



Dimension 1: Creating a culture and language of hope
By focusing on what’s “strong” instead of what’s “wrong” and by eliminating physical barriers, CMHA Calgary encourages its users to share their stories in a safe and welcoming space.



Dimension 2: Recovery is personal
CMHA Calgary emphasizes meeting every service user wherever they are in their own recovery journey.



Dimension 3: Recovery occurs in the context of one’s life
By focusing on co-creation and co-delivery of its courses, CMHA Calgary ensures that Recovery College offerings reflect the perspective of persons with lived and living experience of mental health problems and illnesses and/or substance use.



Dimension 6: Recovery is about transforming services and systems
CMHA Calgary plans to expand its model by bringing Recovery College courses into group homes, further embedding the concept into the city’s health-care system.



Engaging youth on their own terms Implementing recovery-oriented practice: Foundry

Can you offer recovery-oriented practice without using the word recovery? In British Columbia, Foundry is proving that the answer is “yes.” While Foundry’s programs align with the values and dimensions of the MHCC’s Guidelines, it has adapted the language and techniques to reflect the unique needs of the youth, families, and communities it serves.

In a province that has long used recovery in the context of many different health and social issues, such as substance use, the term often leads to varying interpretations among health authorities, service providers, and the public. In 2015, when Foundry opened its first prototype centre in Vancouver, organizers set out to demonstrate how focusing on strengths, needs, and goals — and providing integrated services from a single location — could help young people and their families find the hope and empowerment at the core of the recovery-oriented approach.

Their success has driven the creation of a province-wide network of community-based, evidence-informed, partnership-driven, youth-friendly centres. Since its launch, Foundry has established partnerships with over 200 health-care, community, government, youth, and family-focused organizations. To broaden its reach even further, Foundry’s provincial virtual service was launched in April 2020.

“We work with youth, families, and community leaders who want to dream about new possibilities and co-design solutions to optimize how young people access and receive services,” says Dr. Skye Barbic, Foundry’s research director.

Foundry aims to reach young people before their issues and concerns have a severe impact on their health, relationships, and well-being. It sees each young person as a whole individual, rather than just a set of challenges, and empowers them to determine which services and supports would best help them live a good life. Foundry makes it easy for young people and their caregivers to do that by offering holistic, integrated mental health care,

Foundry

Vancouver, British Columbia (central office), with 11 centres throughout B.C. and 12 more in development

What they do:

Remove barriers and increase access to health and wellness services through a network of welcoming, youth-friendly centres across B.C. and online.

Key recovery-oriented programs:

- Peer support
- Drop-in counselling
- Phone and online chat
- Virtual care services

Implementation insights:

- Adjust recovery language to your audience.
- Integrate services, service providers, youth, and families in an authentic way.
- Collect and analyze recovery-focused data to support quality improvement and innovation.

“It’s no longer about bringing youth to the table but building the table that will allow them to fully participate and lead the way.”

– Skye Barbic, Director of Research

substance use services, physical and sexual health care, youth and family peer supports, and social services (such as housing and employment supports). Lead agencies work with community partners in a coordinated way at each Foundry centre to deliver the services their community needs.

Foundry also engages young people and their families as equal partners and at every stage of centre planning, implementation, and evaluation. This includes decisions about where to place new centres and which clinical options will ensure that services are relevant, youth focused, and meet community needs.

“Foundry is about co-designing new possibilities in youth services,” says Barbic. “It’s no longer about bringing youth to the table but building the table that will allow them to fully participate and lead the way.”

Challenges: One word, many meanings

Beyond its usage in health and social services, the word recovery has also been adopted by the provincial government in reference to economic recovery from COVID-19. As such, it remains a challenge to avoid getting mired in debates about what recovery means in order to focus on serving people the right way.

At the same time, there’s an ongoing need for education about what recovery entails from a mental health context. Government funding windows, for instance, often last just one or two years, but personal recovery journeys often take much longer. “Improving the mental health of communities is a long-term investment that requires a common set of targeted outcomes,” says Barbic.

Foundry works with all partners, including government, to build a sustainable network and system that is flexible and driven by the needs and priorities of young people. “We have a common vision for how we want to work together,” adds Barbic. “This ensures we are driven by common values across the province. We learn and evolve, appreciate individuality, and celebrate community.”

Solutions: Adapt, integrate, and measure

Every Foundry centre is guided by three common approaches for implementing recovery-oriented practice:

- **Adapt.** Foundry knows that what works in one community may not work in another — especially in a province as large as B.C. — and so continuously adapts and expands its programming to meet the needs of diverse youth and their families. It uses terms such as *health*, *wellness*, and *living a good life*, which Barbic says resonate with youth and are developmentally and culturally relevant throughout the entire province.
- **Integrate.** Foundry has integrated more than 200 health-care, community, and government organizations into its network. This allows organizations to share the load and work together in a meaningful way. It also means that any Foundry centre can connect young people to a range of health and social services, supporting them every step of the way so youth can avoid the headaches of having to navigate the complex health and social system on their own.
- **Measure.** From the start, Foundry focused on collecting data that is meaningful to young people and families. This means looking at the strengths and goals of the people who access its services. Foundry builds “health profiles” of young people that capture information on whether they’re pursuing their goals (such as finding a job), their sense of mental well-being and individual empowerment, and more.

Foundry's recovery-oriented practice implementation journey:

2007: Inner City Youth (ICY) program launched by St. Paul's Hospital, Vancouver

2014: Peer support launches as a core ICY service

2015: Granville Youth Health Centre (GYHC) opens as a home for ICY programs and services and is Canada's first integrated health and social service centre for youth and young adults

2015: BC Integrated Youth Services Initiative (BC-IYSIS) launches with funding for 2.5 year proof of concept; five communities identified to establish centres across BC

2016-2017: Foundry brand is launched; GYHC becomes Foundry Vancouver-Granville

2018-2020: Foundry centres open in five additional communities, for a total of 11 centres province-wide

2020: Eight additional Foundry centres announced

2020: Foundry's provincial virtual services launched

Results: Sharing the Foundry model

Foundry currently operates centres in 11 communities from Vancouver to Prince George. In spring 2020, an additional eight communities were identified, so there will be 19 Foundry centres across B.C. by 2023. Online resources and first-of-its-kind virtual care are further extending Foundry's reach throughout the province.

With Foundry in more communities and its services more accessible than ever, young people and their caregivers will no longer have to ask, "Where can I go for help?" That includes youth like Bili, who turned to the organization for guidance and support after she lost her job, her home, and her grandfather.

"Foundry gave me the tools to help cope with my mental illness and worked with me to find an approach that was helpful to me," she says. "My counsellor ensured that I had a support network set up for me."

Despite these successes, the COVID-19 pandemic has compounded the mental health challenges facing youth like Bili — not only in B.C. but all across Canada. That's why Foundry is supporting other communities and organizations that wish to open integrated youth health-service centres of their own, creating guides and standards to help them adapt the Foundry approach to the needs of their regions.

"We've been given the green light to build something new," says Barbic. "We look forward to sharing our learning but also learning from other provinces and territories. Hopefully, this can be a journey for all of Canada to build the best health system in the world for young people."

"We've been given the green light to build something new."

— Skye Barbic, Director of Research

Next Steps: Increasing reach and influence

As Foundry continues to break ground with new centres and new services, Barbic says the organization will continue to be driven by recovery-centred principles and values such as connectedness, hope, identity, meaning, and empowerment.

"We're living the values of the recovery model. We're working closely with youth and families in B.C. to make sure each moment is an opportunity to get better and focus on what matters," she says. "It's about understanding their needs and growing a network where wellness can take shape."



To learn more about Foundry and its programs, visit foundrybc.ca.



For a full list of the skills, behaviours, values, attitudes, and knowledge required to implement all six dimensions, see the complete [Guidelines](#).



How Phoenix Residential Society embodies the dimensions of recovery-oriented practice



Dimension 1: Creating a culture and language of hope

Foundry appreciates individuality and celebrates community.



Dimension 2: Recovery is personal

Each Foundry centre tailors its programming to the needs of its local community and is supported by a vast network of partner services to personalize each young person's wellness journey.



Dimension 3: Recovery occurs in the context of one's life

Foundry involves youth and their families at every stage of program creation and design.



Dimension 5: Working with First Nations, Inuit, and Métis

Foundry is committed to working alongside First Nation, Métis, and Inuit communities; youth; and families to ensure that it is moving in the best direction to support Indigenous cultural safety and humility.



Dimension 6: Recovery is about transforming services and systems

Foundry's network model intentionally integrates health and social service systems, ensuring that many kinds of organizations can share the load and learn from each other.



Seek progress, not perfection

Implementing recovery-oriented practice: Ontario Shores

Ontario Shores became an independent mental health service provider in 2007, after more than a half-century as a provincially run hospital. Its leadership team was resolved to adopt a recovery-oriented model of care but knew it wouldn't be easy given the organization's scale and complexity. Thanks to years of hard work and unwavering commitment from the top, Ontario Shores is now recognized as a leader in recovery-oriented mental health care.

Ontario Shores' success in implementing recovery-oriented practice has been hard won. The leadership team realized early on that training alone wasn't enough to shift the mental health culture rooted in provider-led care that defined recovery as symptom reduction. Two years into the organization's recovery-oriented shift, senior administrative director Mark Rice was tasked with overseeing a recovery action plan that was iterative and consultative, drawing on input from staff in all clinical areas. That front-line engagement allowed the plan to be tailored for different units, gave staff more ownership over change, and fostered lasting transformation.

As a testament to Ontario Shores' embrace of recovery-oriented practice, in 2016, it became the first mental health hospital in Canada to embed a Recovery College within its operations. Based on a model developed in the U.K., the Recovery College helps service users develop autonomy, build on their strengths, and create supportive interpersonal relationships.

Ontario Shores Centre for Mental Health Sciences Whitby, Ontario

What they do:

Deliver a range of specialized services in a hospital setting for those living with complex and serious mental illnesses.

Key recovery-oriented programs:

- Recovery College
- Integrated recovery model of care
- Family involvement
- Culturally competent care
- Recovery measures monitoring integrated with a quality improvement program. E.g.:
 - Recovery Assessment Scale
 - Recovery Promotion Fidelity Scale

Implementation insights:

- Be realistic about the time scale.
- Be prepared to make and learn from mistakes.
- Leverage front-line champions to foster culture change.
- Get real leadership commitment that includes resource allocation and infrastructure.

“We’re supposed to be the experts, so the idea of letting patients tell us what they need challenges that mindset.”

– Mark Rice, Ontario Shores
Senior Administrative Director

Challenges: Shifting perspectives on care

With approximately 350 beds, 1,200 staff, and a wide variety of programs (serving populations ranging from adolescents to seniors), allowing for individualized recovery-oriented treatment while maintaining care standards across the hospital was a massive challenge. As well, although its service providers were supported to incorporate a user-defined model of care into their clinical practices, many — like most in mental health — were used to thinking about recovery in terms of symptom remission, not quality of life.

“Mental health care has been highly paternalistic for a long time,” Rice admits. “As service providers, we often think we’re supposed to be the experts, so the idea of letting patients tell us what they need challenges that mindset.”

Momentum, evolution, and maintaining buy-in were also challenges, given the time and effort required, especially when a particular activity or approach didn't deliver the desired results. Empowering teams and demonstrating leadership commitment were critical in the early days and remain so today.

Solutions: Progress takes time

Ontario Shores has spent more than seven years implementing recovery-oriented practices and isn't done yet. But its unique experience in a large hospital setting has yielded a number of valuable insights:

- **Be realistic.** Change never happens overnight — especially in a large organization. It's important to plan for a long haul from the start.
- **Be prepared to have — and learn from — setbacks.** Things don't always go to plan. When Ontario Shores'

first training program didn't yield instant results, instead of having second thoughts, the organization struck up a recovery advocates group of champions in clinical operations to reinforce recovery thinking on a daily basis. It wasn't that the training had been unsuccessful: it needed more nurturing on the front line.

- **Be guided by principles instead of rules.** One of the recovery advocates group's first activities was to review existing “rules” in light of the recovery approach. Some legacy practices, such as not allowing family members in patient rooms, worked against recovery principles. The group took time to understand what motivated the rules in the first place and, with that in mind, shifted toward principles-based decision making instead of simply adhering to what was “allowed” or “not allowed.” Staff were empowered to use their judgment about when and how to apply the principles themselves. In some cases, long-held “rules” were simply conventions: “Things had just been done a certain way for so long people assumed there was a policy,” says Rice.
- **Measure and assess progress objectively.** To ensure objectivity, Ontario Shores brought in an international expert in 2014 to assess its implementation of recovery-oriented practice. “He actually had more recommendations than we were expecting,” says Rice. “But it was a really useful exercise that helped us steer our action plan in directions we didn't even realize we still had to go.” Today, Ontario Shores uses formal scales, including the [Recovery Assessment Scale](#) to track service user improvements and a [Recovery Promotion Fidelity Scale](#) to track its own implementation.

Ontario Shores' recovery-oriented practice implementation journey:

1919: Opening as a psychiatric hospital

2007: Establishment of a new, recovery-oriented vision

2009: Launch of a recovery model of care throughout the organization

2014: Signing of the MHCC's Recovery Declaration

2016: Launch of Canada's first in-hospital Recovery College and the *Journal of Recovery in Mental Health*

Results: **Making recovery a way of life**

Ontario Shores launched its Recovery College in 2016, creating opportunities for service users, families, and hospital staff to take courses together on a wide range of topics from treatment theory to art and journaling. This strengths-based standpoint is a centrepiece of the hospital's recovery approach today — and was a big part of Lisa's experience when she came to Ontario Shores as a service user. She'd been to other types of therapy and support groups but had not found them particularly helpful. Through the Recovery College, she learned practical skills she could apply and changed the way she thought about recovery and her sense of self.

"I understand now that recovery isn't something you just achieve and now you're recovered," she says. "It's more like a way of looking at life and incorporating preventive maintenance into your life — just like brushing your teeth every day."

Lisa took a number of courses, including Art Cafe, Career Support, and Introduction to Bibliotherapy, and even had the opportunity to create and offer her own course, sharing insights she's learned from self-help books. Today, she is volunteering at Ontario Shores, participating in a service user advocacy committee to help shape hospital policy, and working toward becoming a formal peer support worker.

"Recovery is a way of looking at life and incorporating preventive maintenance into it — just like brushing your teeth every day."

— Lisa, Ontario Shores service user and volunteer

Next Steps: **Fostering connections across the country**

Ontario Shores' Recovery College has been so successful that organizations around the country see it as a model. The organization has provided guidance for several others that have started implementing it in their own settings.

Ontario Shores isn't resting on its laurels: "According to our latest assessment, we are 'moderately implemented,'" says Rice. The organization is considering embedding recovery into job descriptions and postings and is constantly looking for more ways to incorporate more service users and family members into committees across the hospital, including more opportunities for co-design. The organization introduced a course on the [Guidelines](#) into the Recovery College curriculum where new hires and service users learn about recovery. It is also working with external stakeholders to bring more of a recovery focus to post-secondary programs to help students develop mental health literacy and resiliency.

"Implementing recovery is a lot of work, but it's absolutely worth it," he says. "It improves outcomes, it increases staff engagement, and it's the right thing to do."

How Ontario Shores embodies the dimensions of recovery-oriented practice



Dimension 1: Creating a culture and language of hope

The Recovery College supports hope and optimism by presenting a range of possibilities and options for life beyond treatment.



Dimension 2: Recovery is personal

The Recovery College enables participants to focus on and build their own strengths and gives them the autonomy to decide their own paths.



Dimension 3: Recovery occurs in the context of one's life

With a focus on teaching practical skills, the Recovery College empowers students to make positive changes in their own lives.



Dimension 6: Recovery is about transforming services and systems

To better serve its users, Ontario Shores recognized the need to evolve and committed to a long-term vision of recovery, informed by the experiential knowledge of its service users and their families, staff, and the community.



To learn more about Ontario Shores and its programs, visit ontarioshores.ca.



For a full list of the skills, behaviours, values, attitudes, and knowledge required to implement all six dimensions, see the complete [Guidelines](#).



Embracing the challenge of transformation Implementing recovery-oriented practice: Peer Connections Manitoba

As it changed its model from self-help to peer support, Peer Connections Manitoba faced tough decisions about its programs and personnel. But by committing to the recovery philosophy and following the MHCC's Guidelines, the organization has broadened its scope beyond its long-time focus on schizophrenia to help people with a wide range of mental illnesses — and is now bringing peer support into new clinical settings.

Formerly known as the Manitoba Schizophrenia Society (MSS), the organization knew it needed to change along with the province's evolving mental health system, which was shifting toward recovery-oriented practice. To keep pace, it would need to go “all in” on recovery too.

“We could see families wanting us to change from a place that just offered support for their loved ones to one where recovery was not just possible but the expectation,” says Julia Hoepfner, director of operations.

The change would require two things of the organization: expanding its focus beyond a single mental illness and transitioning from its informal self-help approach to intentional, value-based peer support, as outlined by the MHCC.

Challenges: Leaving no part of the organization untouched

The transition to recovery and peer support was gradual and collaborative. Over the course of two years, leadership engaged in regular conversations with staff about possible new approaches to service outcomes, evaluation, and accountability, filtered through the values of peer support. The importance of integrating the voices and views of people with lived or living experience into the organization's programs was also emphasized.

Peer Connections Manitoba Winnipeg

What they do:

Provide mental health education and peer support for Manitobans and their families

Key recovery-oriented programs:

- One-on-one individual and family peer support
- Public education workshops
- Educational support groups

Implementation insights:

- Be clear about your goals.
- Align your people with your strategy.
- Encourage service users to connect with community.

“We could see families wanting us to change from a place that just offered support for their loved ones to one where recovery was not just possible but the expectation.”

— Julia Hoepfner, Director of Operations

Despite the careful planning, some staff members did choose to leave, and some popular programs were retooled or cancelled. A peer support consultant was also engaged to provide additional training and to help the organization update its policies and procedures, as the remaining staff realized they would need some guidance to make the new approach work. That new approach also led to challenges when working with partners in hospitals and other clinical settings, where the focus is on diagnosing and treating illness — and where “recovery” holds a different meaning.

“Staff were asking us really good questions about who we were changing for and if we were doing it the right way,” says Hoepfner.

While mental health organizations typically focus on how service users benefit from their programs (the “outcomes”), they face pressure from provincial health ministries to show how a new approach can help more people at a lower cost (the “output”). This challenged the Peer Connections Manitoba team to collect and analyze its performance data in new ways.

“There's always a dichotomy,” says executive director Sean Miller. “How can we evaluate ourselves in a way that satisfies our funders but also helps us understand the full scope of our own impact?”

After rolling out the peer support model, the organization soon realized there was one final barrier to overcome to fully realize its potential: its name, which had been MSS for more than 40 years. Keeping that name would limit its ability to recruit the peer support workers and develop the programs it would need to serve all Manitobans, not only those living with schizophrenia.

“Our proudest moment came from recognizing the stigma of being a single-illness organization and being able to get through that,” says Hoepfner.

Solutions: Lessons learned to implement recovery-oriented practice

In 2020, the MSS officially changed its name to Peer Connections Manitoba. Throughout its transformation journey, it has learned many valuable lessons about implementing recovery-oriented practice. These include the following principles:

- **Align your team “from stem to stern.”** The organization reshaped its board of directors by bringing on only individuals who identified with the recovery philosophy. It also changed its hiring procedures so that people with lived or living experience of mental illness were included to help inform program development.
- **Familiarize yourself with the Guidelines.** “It's important to have your ‘aha’ moment before you start,” says Hoepfner. “Realizing that peer support and recovery go hand in hand was that moment for us.”
- **Be clear about how structured you want your program to be.** Peer Connections Manitoba knew it wanted to be a formal, professional program rather than a “clubhouse.” That meant investing in accredited training and certifying staff and peer support workers to national standards.
- **Engage with other service providers.** Although you're trying to deliver the best possible services, you're not competing with other providers. Improving peer support across the board means working with others that do it too.
- **Encourage service users to connect with the community.** Providing service users with opportunities to share their stories with the broader community can help them along their own recovery journeys. “We're trying to build a culture of connection,” says Miller.
- **Show your results.** As a self-help organization, Peer Connections Manitoba had done little data collection. Since the shift to peer support, it has established robust evaluation processes based on quantitative and qualitative feedback, making it easier to evaluate effectiveness and show impact to the government — a must to secure funding.

**Peer Connections
Manitoba's recovery-
oriented practice
implementation journey:**

1979: Founded as Manitoba Schizophrenia Society

2000s: Embraced philosophy of recovery-oriented practice

2019: Began transition to peer support model

2020: Launched new peer support program in clinical settings

2020: Changed name to Peer Connections Manitoba

“Getting my recovery story on paper and sharing it with the community is such a healing experience. It’s been really beneficial.”

– Tamara, Peer Connections Manitoba service user

Results: Expanded services and important new partners

With a new identity, Peer Connections Manitoba is no longer “pigeonholed” as a single-illness organization and can instead provide an expanded array of programs and services to more people. One such person is Tamara, who is moving forward in her recovery journey by serving on the organization’s board; co-facilitating youth workshops; participating in the organization’s drama group; and sharing her story at schools, police departments, and hospitals.

“For me, the hugest part of recovery is giving back to other people,” she says. “Getting my recovery story on paper and sharing it with the community is such a healing experience. It’s been really beneficial. The reason I’m doing so well in my recovery journey is because of the opportunities I have to support and encourage others along their own journeys.”

For organizations looking to implement a recovery-oriented approach, Tamara recommends they try to offer several options for people to explore recovery based on their individual goals and interests. “Different things will interest different people,” she says. “Sometimes all it takes is one seed planted.”

With its recovery-oriented model fully in place, Peer Connections Manitoba was able to launch a new program in 2020 that brings peer support into clinical settings: a crisis support centre in Winnipeg and an emergency department in Dauphin. While the clinical teams initially viewed the peer support workers as competition, a focus on peer support training and education has helped bring everyone involved in a service user’s recovery journey onto the same page.

“We took the competition out by acknowledging that clinicians have a huge role to play,” says Hoepfner. “I don’t have the words to describe how thankful I am to be able to create relationships and connections in an environment I never believed we’d be able to engage.”

Next Steps: Maintaining the momentum

Peer Connections Manitoba is now focused on maintaining its momentum, and continuing to invest in its staff will be key.

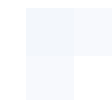
“Staff competency plays a huge role, especially from the perspective of people in the clinical space and those watching what we’re doing,” says Miller. “It’s about really embedding every aspect of recovery-oriented practice from the top down: putting those strategies in place, identifying our values and culture, and recognizing how that translates into actual practice.”



To learn more about Peer Connections Manitoba and its programs, visit peerconnectionsmb.ca.



For a full list of the skills, behaviours, values, attitudes, and knowledge required to implement all six dimensions, see the complete [Guidelines](#).



How Peer Connections Manitoba embodies the dimensions of recovery-oriented practice



Dimension 1: Creating a culture and language of hope

By discussing its commitment to recovery during the hiring process, Peer Connections Manitoba ensures that every new staff member embeds recovery principles further into the organization’s culture.



Dimension 2: Recovery is personal

Peer Connections Manitoba encourages individuals to make their own decisions about what’s best for their mental health.



Dimension 3: Recovery occurs in the context of one’s life

By encouraging service users to share their recovery stories with others, the organization helps them maintain important connections to the broader community.



Dimension 6: Recovery is about transforming services and systems

Peer Connections Manitoba is building connections to important healthcare stakeholders by bringing peer support into clinical settings and reporting on the results it’s delivering to the community using a robust, data-driven evaluation program.



Where community is key Implementing recovery-oriented practice: Phoenix Residential Society

For more than 40 years, Phoenix Residential Society has worked to help people with mental health, cognitive, and substance use challenges take control of their journeys. Its recovery-focused approach is well aligned with the [Guidelines](#), emphasizing personal choice, independent living, and — especially — community connection.

The first Phoenix group home in 1979 blended therapeutic interventions with support for people's daily functioning and social interactions. As evidence-based practices in recovery and rehabilitation have matured, Phoenix has also evolved, transitioning from a group home environment to apartment living that supports personal autonomy and life-skills development. All along, a major focus has been to help foster meaningful community relationships and individuals' sense of personal purpose.

Phoenix began certifying its leadership team and staff to the psychosocial rehabilitation (PSR) standard in the early 2000s as a way of formalizing its recovery approach. To reflect the Canadian context, the organization switched its certification regime to PSR Canada in 2016 and continues to ensure that all staff keep their certification up to date.

Phoenix Residential Society Regina, Saskatchewan

What they do:

Provide community-based housing services supported by psychosocial rehabilitation

Key recovery-oriented programs:

- Phoenix apartment living services (PALS)
- Pearl program for acquired brain injury
- Phoenix HOMES program
- Supportive, apartment-based residential programs

Implementation insights:

- Build programs around existing tools or systems that align with your values rather than creating them from scratch.
- Use the reflection questions in the Guidelines to inform rich discussions for continuous improvement.
- Advocacy for broader system change is ongoing.

“It can be disheartening for someone to reach a place where they're feeling positive about their recovery only to have funding criteria reduce their whole identity to their condition.”

– Sheila Wignes-Paton, Phoenix Residential Society
Executive Director

Challenges: The ongoing struggle against stigma

Phoenix Residential Society's challenges implementing a recovery-oriented approach have tended to come from outside rather than within. Stigma in particular is a persistent barrier according to executive director Sheila Wignes-Paton, making it hard for service users to get jobs, engage in meaningful interpersonal relationships, and find acceptance.

“Sometimes the fear of stigma (or past experiences with it) can also make people unwilling to pursue opportunities where they risk rejection because of their mental health status,” Wignes-Paton says.

While COVID-19 restrictions have more recently created new barriers to community contact — employment, outings, and activities — these are recognized as temporary. A more persistent challenge is the fact that government program funding criteria tend to focus on addressing deficiencies, treating problems, and labelling mental health conditions rather than on fostering and supporting a person's strengths.

“It can be disheartening for someone to reach a place where they're feeling positive about their recovery only to have funding criteria reduce their whole identity to their condition,” Wignes-Paton says.

Solutions: Harnessing the power of partners and peers

In pursuing its goals and responding to the challenges encountered along the way, Phoenix has gained a number of insights into implementing recovery-oriented practices successfully:

- **Use partners as champions.** Phoenix's focus on community integration makes external partners key — from local associations offering art classes to the Regina Police crisis outreach and support team. These partnerships not only provide information, services, and even jobs for service users, but also help raise awareness and reduce stigma. Phoenix works closely with its partners to ensure that they understand recovery, why it matters, and how they can contribute.
- **Promote peer support everywhere you can.** Formal and informal peer support are foundational to helping individuals forge healthy relationships and pursue their recovery goals — by modelling the possibilities of recovery and providing motivation and friendship.
- **Advocate for system change.** While Phoenix has no direct control over non-recovery-oriented government funding criteria, it advocates for system transformation on behalf of its service users and supports appeals of unjust funding decisions.
- **Leverage existing tools (that align with your values).** Few organizations have the time, money, or expertise to reinvent the wheel. Taking advantage of recovery-oriented resources helps accelerate progress with less effort. Phoenix used the PSR framework as a basis to guide its service development and plans to incorporate the MHCC's Guidelines into its operations as well.

Phoenix Residential Society's recovery-oriented practice implementation journey:

1979: Opening of Phoenix House, Saskatchewan's first mental health-focused group home

1984: Launch of the PALS program to foster independence

2002: Certification of leadership team in psychosocial rehabilitation (international)

2006: Full transition from group home to apartment living model

“My recovery plan wasn't just handed to me; I helped create it.”

– Cole, Phoenix Residential Society service user and employee

Results: Always striving for improvement

Today, Phoenix's multiple apartment facilities are home to more than 180 residents and offer a range of services and activities, many led by peer supporters. The organization serves people with lived and living experience of mental health problems or illnesses and/or substance use, acquired brain injuries, and other cognitive disabilities, as well as those experiencing chronic homelessness.

To help service users track their own progress and to measure the impact of its recovery-oriented programs, Phoenix uses a mix of assessment tools including the [Camberwell Assessment of Need](#), the [Personal Recovery Outcome Measure](#), and the [Multnomah Community Ability Scale](#). Results continue to show ongoing improvement in energy levels, relationship satisfaction, housing situations, substance use, physical health, and more.

Cole, who first came to Phoenix in 2012 struggling with anxiety and substance use, says one of the important parts of the Phoenix recovery approach for him was having control over his own personal recovery plan.

“My recovery plan wasn't just handed to me; I helped create it,” he says. “Having it really helps, because even if I have a hard day, just knowing there's a plan gives me the confidence to move forward.”

Through counselling, therapy, and peer support, Cole has worked steadily toward his recovery goals. Today he is married and self-sufficient, working part-time at the front desk of one of the Phoenix apartment buildings and staying actively involved in the Phoenix community as a peer supporter.

Next Steps: Putting the focus on peers

Phoenix is continuing to expand the role of peer supporters across its offerings and will draw increasingly on their input for program development. It also conducts surveys to identify service gaps and areas for improvement and has established advisory groups of people with lived experience and family members to gather more in-depth feedback and suggestions.

Wignes-Paton says she's started to work the reflection questions from the Guidelines into staff meetings, using them as an insightful and thought-provoking tool to facilitate important conversations.

“When we started to really focus on recovery, we had a lot of meetings about what we wanted it to look like, and those questions would have been really useful then,” she says. “For anyone embarking on the journey now, I highly recommend taking advantage of them.”



To learn more about Phoenix Residential Society and its programs, visit phoenixregina.com.



For a full list of the skills, behaviours, values, attitudes, and knowledge required to implement all six dimensions, see the complete [Guidelines](#).

How Phoenix Residential Society embodies the dimensions of recovery-oriented practice



Dimension 1: Creating a culture and language of hope
Integrating peer support throughout its services helps Phoenix foster a sense of hope and optimism, as service users see daily examples of others with mental health challenges living full and fulfilling lives.



Dimension 2: Recovery is personal
Individuals are actively involved in setting their own recovery goals and making plans to achieve them. Phoenix works closely with external partners to ensure that all service users have access to services and supports tailored to their unique needs.



Dimension 3: Recovery occurs in the context of one's life
Phoenix's approach focuses strongly on community integration, supporting service users as they pursue meaningful relationships and personal purpose.



Dimension 6: Recovery is about transforming services and systems
Phoenix stays informed of the latest evidence and best practices, and advocates with governments and other stakeholders for system change, particularly with respect to funding criteria.



Start small and fully commit

Implementing recovery-oriented practice: Reach Out Centre for Kids

When the Reach Out Centre for Kids (ROCK) found one of its family health team partners struggling to connect and communicate with service users, it knew it needed to try something more than the usual case management approach. That spurred a years-long implementation of recovery-oriented methods in line with the [Guidelines](#) that's now spreading throughout ROCK.

To help its family health team partner better understand and connect with community-based child and youth mental health systems, ROCK launched the Caroline Families First program in 2013. In searching for an evidence-based foundation to anchor the program, ROCK chose [wraparound care](#), a model that brings together service providers, care coordinators and families to co-create truly individualized treatment plans for every family. The family leads all decisions, including who's on the care team, what the recovery goals are, and what the timeline looks like. These decisions may be very different from one family to the next and often result in a plan that bears little resemblance to a "standard" treatment plan.

"When the *Guidelines for Recovery-Oriented Practice* came out in 2015, they validated the work we were doing," says Michelle Domonchuk-Whalen, Caroline Families First program manager. "They aligned with the values and principles of wraparound."

The Caroline Families First team all received training in the wraparound model, and the program manager and lead became certified trainers and coaches. The team delivers regular presentations to the rest of the organization and the community about the benefits of the family-first model and is working to create more wraparound units throughout ROCK.

Reach Out Centre for Kids Burlington, Ontario

What they do:

Serve children and youth with mental health problems or illnesses and their families in the Halton area

Key recovery-oriented programs:

- Caroline Families First
- Caregiver peer support services

Implementation insights:

- Take an incremental approach.
- Take care of families and caregivers.
- Don't reinvent the wheel.

**"The Guidelines
validated the work we
were doing and aligned
with our values and
principles."**

– Michelle Domonchuk-Whalen,
ROCK Program Manager

Challenges: Charting new territory

Recovery principles are well established in adult care but less so in the child and youth context. That's partly because recovery is rooted in personal authority and autonomy, yet younger children may not be able to articulate their own needs, and older youth may disagree with their caregivers on key issues. Recovery becomes about empowering a wider care circle, such as the family, and balancing different perspectives within it. There weren't many ready-made models when Caroline Families First started out.

Structural stigma is also a challenge: while institutions and organizations such as schools that have little understanding of recovery principles, they are intimately involved in children's lives. Domonchuk-Whalen recalls accompanying a parent to a school meeting and being met by an entire room full of people all typing on laptops. "It wasn't an environment that was going to make anyone feel at ease, so I asked if they all needed to be taking notes and if we could have fewer people in the room once the youth joined us." She calls that kind of gentle intervention "compassionate disruption."

Stigma can extend to funding guidelines, which often don't cover supports for families and caregivers despite their critical role in child and youth mental health.

Solutions: Focus on the whole family

Working with families has given ROCK a unique perspective on implementing recovery-oriented practice in a child- and youth-focused setting. Along the way, they've learned some key lessons:

- **Start small and do it well.** Completely changing an entire organization overnight is unrealistic, and a

half-hearted pilot project without real support won't ever gain organization-wide traction. "You can't just sprinkle in a token idea and expect it to stick," says Domonchuk-Whalen. "It won't be authentic, and it will be hard to get buy-in."

ROCK focused on developing and supporting the new model within a single program, making sure all the pieces were in place and implemented fully. Following that success, they expanded the model to a second family health team, and now the rest of ROCK is taking notice.

- **Support caregiver wellness to support child and youth recovery.** To achieve the best outcomes for youth, their families, parents, and caregivers also need support. To meet those needs, ROCK has a growing set of caregiver peer support services, including a community of practice that meets regularly. Alison is a parent and foster parent who has used ROCK's services for years and is part of that community of practice. She and other peer support colleagues created a drop-in group to give caregivers the opportunity to socialize and talk about more trivial topics with others who understand their context. She was also instrumental in launching a pilot project to incorporate caregiver peer support into ROCK's walk-in clinic.

"I used to sit in the waiting room, agonizing over what he's telling the therapist, what the therapist thinks of me as a parent, and even what I'm going to say to him on the way home," she says. "I would have loved for someone to come out and ask me how I was doing."

- **Look to existing resources to support your efforts.** Resources like the Guidelines provide a wealth of information and guidance, and Domonchuk-Whalen recommends reaching out to other organizations for their insights. "Plenty of organizations have contacted us, and we're always happy to share what we've learned and experienced," she says.

ROCK's recovery-oriented practice implementation journey:

2013: Launch of wraparound care model

2014: Designation as the child and youth mental health Lead Agency for Halton

2020: Launch of caregiver peer support at the walk-in clinic

“The clinician can explain the science, but I can give real examples of what emotion-focused family therapy actually looks like in your day.”

– Alison, parent, foster parent, and ROCK peer supporter

Results: **Family-led at every stage**

ROCK policy now requires that families be directly involved with the creation of care plans, and it's the families who decide when they've achieved their goals and are ready to move on from care. Peer support workers are involved in more and more of ROCK's work, and a range of measurement tools, including client satisfaction surveys, caregiver strain questionnaires, and goal attainment scaling, show that the model works.

“When we first started down this path, the Ministry of Health wouldn't recognize peer support workers as a fundable position,” says Domonchuk-Whalen. “But when our funding was renewed two years ago, they didn't even bat an eye.”

After a successful pilot, the walk-in clinic now has caregiver peer support regularly available, and the participation of peer support workers in emotion-focused family therapy has been so valuable that they are now included as co-facilitators.

“The clinician can explain the science, but I can give real examples of what emotion-focused family therapy actually looks like in your day,” says Alison.

Next Steps: **A leading wedge for the whole organization**

As other parts of ROCK have recognized the benefits peer support and lived experience have delivered, the organization has incorporated it into more programs and continues to look for areas to include more lived experience. ROCK's vice-president of services makes time to attend the peer support workers community of practice meetings whenever possible, highlighting the importance of not just including lived experience in decision making, but also of bringing leadership into the lived experience arena.

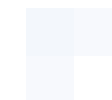
“We've had a great, successful start bringing lived experience into some of our programs,” says Domonchuk-Whalen. “Now we want to use the success of Caroline Families First as a leading wedge to embed this model everywhere we can.”



To learn more about ROCK and its programs, visit rockonline.ca.



For a full list of the skills, behaviours, values, attitudes, and knowledge required to implement all six dimensions, see the complete [Guidelines](#).



How ROCK embodies the dimensions of recovery-oriented practice



Dimension 1: Creating a culture and language of hope

ROCK's peer support programs help families and caregivers see life beyond the mental health diagnosis and foster hope and optimism for the future.



Dimension 2: Recovery is personal

Through ROCK's commitment to family-led care, every family gets to decide what their goals are, what kind of help they need, who should provide it, and when they're ready to move on.



Dimension 3: Recovery occurs in the context of one's life

ROCK recognizes that family, school, community, and home life are critical elements in child and youth mental health recovery and must be considered at all stages of care. By empowering families to take charge of their own care decisions, ROCK also helps ensure treatment and recovery fit into their lives and meet their needs.



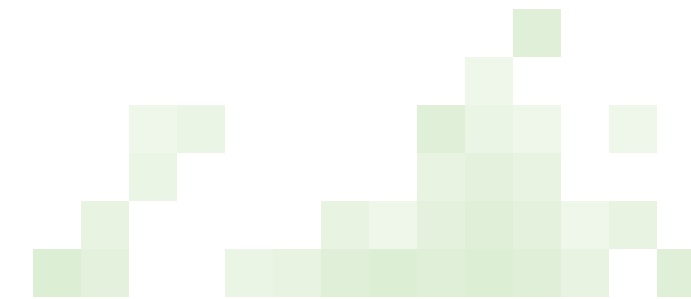
Dimension 4: Responding to the diverse needs of everyone living in Canada

ROCK's wraparound care model helps smooth the transitions between child and youth mental health care and eventually into adult care.



Dimension 6: Recovery is about transforming services and systems

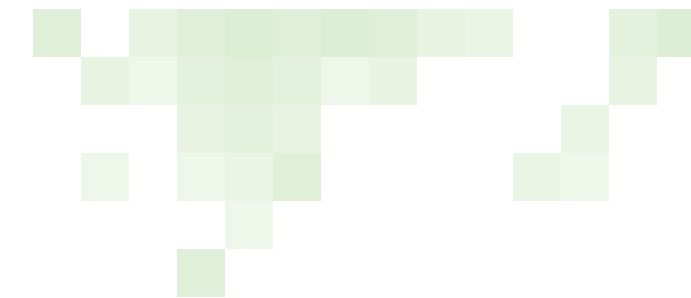
Led by the Caroline Families First program, ROCK is transforming the way it provides services and is helping the broader system recognize the benefits of peer support and recovery-oriented approaches.



Section 6: **Tools and templates**

This section provides a repository of practical resources that can help you put recovery-oriented practice into action in your organization. These include examples of:

- an organizational assessment
- an action plan
- a learning and development plan
- and more.



Organizational Assessment for Recovery-Oriented Practice

Process

Factor Description	Identify (✓)	Factor Level
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Choose the **factor level** that comes closest to your situation and tick the box left of it.

Benefits beyond helping patients

- In addition to helping patients, are there other benefits to recovery-oriented practice?
- Will staff notice a difference in their daily working lives by practicing recovery approaches?

- A** We can demonstrate that recovery-oriented practice has a wide range of benefits beyond helping patients, such as benefits to the community and the health care system.
- B** We can demonstrate that recovery-oriented practice has more than three beyond helping patients such as benefits to the community.
- C** We can demonstrate that recovery-oriented practice has one or two benefits beyond helping patients.
- D** The benefits we have identified are only directly related to helping patients. We have not identified any other benefits that recovery-oriented practice could bring.

Credibility of the benefits

- Are benefits of recovery-oriented practice to patients, staff and the organization visible?
- Do staff believe in the benefits of recovery-oriented practice?
- Can all staff clearly describe the full range of benefits associated with recovery-oriented practice?
- Is there evidence that recovery-oriented practice has been achieved elsewhere?

- A** Benefits of recovery-oriented practice are widely communicated, immediately obvious, supported by evidence and believed by stakeholders. Staff are able to fully describe a wide range of intended benefits for recovery-oriented practice.
- B** Benefits of recovery-oriented practice are not widely communicated or immediately obvious even though they are supported by evidence and believed by stakeholders.
- C** Benefits of recovery-oriented practice are not widely communicated or immediately obvious even though they are supported by evidence. They are not widely believed by stakeholders.
- D** Benefits of recovery-oriented practice are not widely communicated, they are not immediately obvious, nor are they believed by stakeholders.

Process

Factor Description	Identify (✓)	Factor Level
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Adaptability of improved process

- Can recovery-oriented practice and new associated processes overcome internal pressures, or will this disrupt the change?
- Does recovery-oriented practice continue to meet ongoing needs effectively?
- Does recovery-oriented practice rely on a specific individual or group of people, technology, finance, etc. to keep it going?
- Can recovery-oriented practice keep going when these are removed?

- A** Recovery-oriented practice and associated processes can adapt to link in with, and even support, other organizational changes. It would not be disrupted if specific individuals or groups left the organization, its focus will continue to meet the improvement needs of our organization.
- B** Recovery-oriented practice and associated processes can be adapted to support wider organizational change but it would be disrupted if specific individuals or group left the organization. Elements of this work will continue to meet our organization's improvement needs.
- C** It would be difficult to adapt recovery-oriented practice and associated processes to other organizational changes. It would cause disruption if specific individuals or groups left the organization.
- D** Recovery-oriented practice and associated processes can not adapt if there was any other organizational change happening and it would be disrupted if specific individuals or groups left the organization.

Effectiveness of the system to monitor progress

- Does recovery-oriented practice require special monitoring systems to identify and continually measure improvement?
- Is there a feedback system to reinforce benefits and progress and initiate new or further action related to recovery-oriented practice?
- Are mechanisms in place to continue to monitor progress of recovery-oriented practice beyond the formal life of the implementation plan?
- Are the results of recovery-oriented practice communicated to patients, staff, the organization and wider healthcare community?

- A** There is a system in place to provide evidence of impact, monitor progress, and communicate the results of recovery-oriented practice. This is set up to continue beyond the formal life of the implementation plan.
- B** There is a system in place to provide evidence of impact, monitor progress, and communicate the results of recovery-oriented practice. This is not set up to continue beyond the formal life of the implementation plan.
- C** There is a system in place to provide evidence of impact and monitor progress. However, none of this information is communicated more widely than the core project team. The measurement system is not set up to continue beyond the formal life of the project.
- D** There is only a very patchy system to monitor progress of recovery-oriented practice and this will end at the same time as the implementation plan. There is no system to communicate the results.

Staff

Factor Description	Identify (✓)	Factor Level
<p>Staff involvement and training to sustain the process</p> <ul style="list-style-type: none"> Do staff play a part in innovation, design, and implementation of the change process toward recovery-oriented practice? Have staff used their ideas to inform the change process toward recovery-oriented practice from the beginning? Is there a training and development infrastructure to identify gaps in skills and knowledge, and are staff educated and trained in recovery-oriented practice? 	<p>A <input type="radio"/></p> <p>B <input type="radio"/></p> <p>C <input type="radio"/></p> <p>D <input type="radio"/></p>	<p>Staff have been involved from the beginning of the change process toward recovery-oriented practice. They have helped to identify any skill gaps and have been able to access training and development so they are confident and competent in recovery-oriented practice.</p> <p>Staff have been involved from the beginning of the change process toward recovery-oriented practice. They have helped to identify skill gaps but have not had training or development in recovery-oriented practice.</p> <p>Staff have not been involved from the beginning of the change process toward recovery-oriented practice but they have received training in recovery-oriented practice.</p> <p>Staff have not been involved from the beginning of the change process and have not had training or development in recovery-oriented practice.</p>
<p>Staff behaviours toward sustaining the change</p> <ul style="list-style-type: none"> Are staff encouraged and able to express their ideas regularly throughout the change process toward recovery-oriented practice and is their input taken on board? Do staff think that recovery-oriented practice is a better way of providing care? Are staff trained and empowered to run small-scale tests (Plan, Do, Study, Act cycles) based on their ideas, to see if additional improvements in recovery-oriented practice should be recommended? 	<p>A <input type="radio"/></p> <p>B <input type="radio"/></p> <p>C <input type="radio"/></p> <p>D <input type="radio"/></p>	<p>Staff are able to share their ideas regularly and some of them have been taken on board during the implementation plan. They believe that recovery-oriented practice is a better way of providing care and have been empowered to run small scale test cycles (Plan, Do, Study, Act).</p> <p>Staff are able to share their ideas regularly and some of them have been taken on board during the implementation plan. They believe that recovery-oriented practice is a better way of providing care. Staff do not feel empowered to run small scale test cycles (Plan, Do, Study, Act).</p> <p>Staff are able to share their ideas regularly but none seem to have been taken on board during the implementation plan. They don't think that recovery-oriented practice is a better way of providing care. They don't feel empowered to run small scale test cycles (Plan, Do, Study, Act).</p> <p>Staff do not feel they have been able to share their ideas. They do not believe that recovery-oriented practice is a better way of providing care, and they have not been empowered to run small scale test cycles (Plan, Do, Study, Act).</p>

Staff

Factor Description	Identify (✓)	Factor Level
<p>Senior leadership engagement and support</p> <ul style="list-style-type: none"> Are the senior leaders trusted, influential, respected and believable? Are senior leaders involved in the plan to implement recovery-oriented practice, do they understand it and promote it? Are senior leaders respected by their peers and can they influence others to get on board? Are senior leaders taking personal responsibility to help break down barriers and are they giving time to help ensure the plan to implement recovery-oriented practice is successful? 	<p>A <input type="radio"/></p> <p>B <input type="radio"/></p> <p>C <input type="radio"/></p> <p>D <input type="radio"/></p>	<p>Organizational leaders are highly involved and visible in their support of change towards recovery-oriented practice. They use their influence to communicate the impact of recovery-oriented practice and to break down any barriers. Staff regularly share information with and actively seek advice from leaders.</p> <p>Organizational leaders are highly involved and visible in their support of change towards recovery-oriented practice. They use their influence to communicate the impact of recovery-oriented practice and to break down any barriers. Staff occasionally share information with and actively seek advice from leaders.</p> <p>Organizational leaders are somewhat involved but not highly visible in their support of change towards recovery-oriented practice. They use their influence to communicate the impact of recovery-oriented practice but cannot be relied upon to break down any barriers if things get difficult. Staff typically don't share information with or seek advice from leaders.</p> <p>Organizational leaders are not involved or visible in their support of change towards recovery-oriented practice. They have not used their influence to communicate the impact of recovery-oriented practice or break down any barriers. Staff typically don't share information with or seek advice from leaders.</p>

Staff

Factor Description	Identify (✓)	Factor Level
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Clinical leadership engagement and support

- Are the clinical leaders trusted, influential, respected and believable?
- Are clinical leaders involved in the plan to implement recovery-oriented practice, do they understand it and promote it?
- Are clinical leaders respected by their peers and can they influence others to get on board?
- Are clinical leaders taking personal responsibility to help break down barriers and are they giving time to help ensure the plan to implement recovery-oriented practice is successful?

- A Clinical leaders are highly involved and visible in their support of change towards recovery-oriented practice. They use their influence to communicate the impact of recovery-oriented practice and to break down any barriers. Staff regularly share information with and actively seek advice from clinical leaders.
- B Clinical leaders are highly involved and visible in their support of change towards recovery-oriented practice. They use their influence to communicate the impact of recovery-oriented practice and to break down any barriers. Staff occasionally share information with and actively seek advice from clinical leaders.
- C Clinical leaders are somewhat involved but not highly visible in their support of change towards recovery-oriented practice. They use their influence to communicate the impact of recovery-oriented practice but cannot be relied upon to break down any barriers if things get difficult. Staff typically don't share information with or seek advice from clinical leaders.
- D Clinical leaders are not involved or visible in their support of change towards recovery-oriented practice. They have not used their influence to communicate the impact of recovery-oriented practice or break down any barriers. Staff typically don't share information with or seek advice from clinical leaders.

Organization

Factor Description	Identify (✓)	Factor Level
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- A The goals of the change towards recovery-oriented practice are clear and have been shared widely. They are consistent with and support the organization's strategic aims for improvement. The organization has demonstrated successful sustainability of improvements in recovery-oriented practice before and has a 'can do' culture.

Organization

Factor Description	Identify (✓)	Factor Level
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Fit with the organization's strategic aims and culture

- Are the goals of the change towards recovery-oriented practice clear and shared?
- Are the goals around recovery-oriented practice clearly contributing to the overall organizational strategic aim?
- Is improving recovery-oriented practice important to the organization and its leadership?
- Has the organization successfully sustained improvement in recovery-oriented practice in the past?

- B The goals of the change towards recovery-oriented practice are clear and have been shared widely. They are consistent with and support the organization's strategic aims for improvement. The organization has demonstrated limited success in sustaining previous improvements in recovery-oriented practice before and does not have a 'can do' culture.
- C The goals of the change towards recovery-oriented practice are clear and have been shared widely. They have not been linked with the organization's strategy so we don't know if they support any organizational aims for improvement. The organization has not demonstrated success in sustaining previous improvements in recovery-oriented practice before and does not have a 'can do' culture.
- D The goals of the change towards recovery-oriented practice are not really clear and they have not been shared widely. They have not been linked with the organization's strategy so we don't know if they support any organizational aims for improvement. The organization has not demonstrated success in sustaining previous improvements in recovery-oriented practice before and does not have a 'can do' culture.

Infrastructure

- Are the staff fully trained and competent in recovery-oriented practice?
- Have the right facilities, equipment, and resources been acquired to support recovery-oriented practice?
- Are new recovery-oriented practice requirements built into job descriptions?
- Are there policies and procedures supporting recovery-oriented practice?
- Is there a communication system in place about recovery-oriented practice?

- A Staff are confident and trained in recovery-oriented practice. Job descriptions, policies, and procedures reflect the new process and communication systems are in place. Facilities and equipment are all appropriate to sustain recovery-oriented practice.
- B Staff are confident and trained in recovery-oriented practice. However, job descriptions, policies, and procedures do not reflect the new process. Some communication systems are in place. Facilities and equipment are all appropriate to sustain recovery-oriented practice.
- C Staff are confident and trained in recovery-oriented practice. However, job descriptions, policies, and procedures do not reflect the new process and there are no communication systems to adequately support the new process. Facilities and equipment are not appropriate to sustain recovery-oriented practice.
- D Staff have not been trained in recovery-oriented practice and are not confident in the new way of working. Job descriptions, policies and procedures do not reflect the new process and there are no communication systems to adequately support the new process. Facilities and equipment are not appropriate to sustain recovery-oriented practice.

Master Score System: Enter your scores

Process Benefits beyond helping patients	Write your score in the circle	a 8.5 b 4.7 c 4.0 d 0.0	Process Credibility of the benefits	Write your score in the circle	a 9.1 b 6.3 c 3.1 d 0.0
Process Adaptability of improved process	Write your score in the circle	a 7.0 b 3.4 c 2.4 d 0.0	Process Effectiveness of the system to monitor progress	Write your score in the circle	a 6.5 b 3.3 c 2.4 d 0.0
Staff Staff involvement and training to sustain the process	Write your score in the circle	a 11.4 b 6.3 c 4.9 d 0.0	Staff Staff behaviours toward sustaining the change	Write your score in the circle	a 11.0 b 5.1 c 5.1 d 0.0
Staff Senior leadership engagement	Write your score in the circle	a 15.0 b 6.2 c 5.7 d 0.0	Staff Clinical leadership engagement	Write your score in the circle	a 15.0 b 6.7 c 5.5 d 0.0
Organization Fit with the organization's strategic aims and culture	Write your score in the circle	a 7.0 b 3.5 c 3.3 d 0.0	Organization Infrastructure for sustainability	Write your score in the circle	a 9.5 b 4.4 c 3.3 d 0.0



A download of the [template](#) is available.

Calculate your total scores

Process	total score	
+		
Staff	total score	
+		
Organization	total score	
=		
Sustainability	total score	date

To calculate your score, use the Master Score System. Add the **Process**, **Staff** and **Organization** scores together and place in the **Sustainability total score** box above.



Bar Chart and Portal Diagram:
plot your scores and identify which factors require most attention.

Interpreting your scores?

We do advocate that you use the [Sustainability Model](#) at the beginning of your improvement initiative as it can provide you with a valuable understanding of where you can strengthen your work in order to maximise the potential for sustainability. You need to note that at this stage it is normal to have low scores in one or two of the factors. For example; infrastructure often has a low score initially as the tasks of fully training staff in the new process and reviewing role descriptions are usually undertaken later in the project. With each score teams should assess what the score means to them in their particular context. Use the scores as a reminder of important tasks even if they need to be undertaken at a later stage.



Recovery-oriented Practice Learning and Development Plan Template

Name:	Organization:	Team:	Leader:
Dimension of Recovery	Skills/Guidelines to Improve	Goals	Strategies
Sources of Funding	Updates (What have you learned?)	Evaluation	Outcomes



A download of the [template](#) is available.

Recovery-Oriented Practice Action Plan Template

Date: _____

Team Members			
Dimension of Recovery and Guidelines to Improve			
Goal			
Implementation Strategies	Lead Responsible	Date to Begin	Date Due
Measurement			
Positive Outcomes	Baseline Metric	Target Metric	



A download of the [template](#) is available.



Conclusion

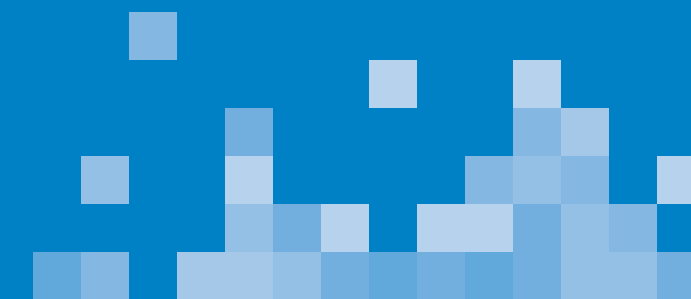
The implementation of the Guidelines will help to enhance and normalize the consistent use of recovery principles in health care.

Moving forward, it is imperative that individuals and organizations remain steadfast in their commitment to their adoption in the delivery of mental health and substance use services.

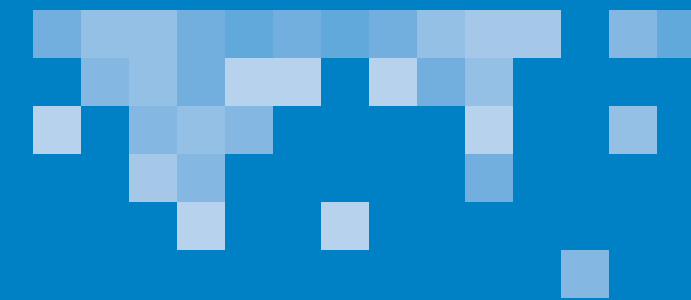
Every workplace and individual is unique. However, living the core recovery principles each and every day will give organizations the opportunity to influence policies, programs, and practices that will lead to positive outcomes, both for service users and caregivers.

References

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