Recovery Education and Training Overview

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- Recovery education delivers the **knowledge** that mental health professionals require.
- Training provides the **skills** they need to offer recovery-oriented practice.
- **Co-production** helps them contextualize this education and training — in relation to the services they provide and the persons who access them.

Recovery Education

Mental health professionals need meaningful and practical ways to support personal recovery. In Canada, because the concept of personal recovery is relatively new, it is likely that they continue to look to clinical improvements where recovery is concerned. Education should therefore include a practical working definition of personal recovery and how this concept differs from the clinical aspects of care.

Contrast Between Clinical Recovery and Personal Recovery

Clinical Recovery	**Personal Recovery**
Need correct diagnosis	Not driven by diagnosis
Driven by a professional	Can be supported by anyone
Often driven by manualized linear models of care	Non-linear
Not guaranteed	Always possible

Recovery Education — CHIME Framework

Although everyone's story is unique,[i] researchers have found that recovery journeys usually have five components (CHIME Framework):

Recovery Component	**Suggested Themes**
Connection (Guidelines dimensions 3 and 5)	• Acknowledge that mental illness can be isolating. Connection is one of the most important ways to buffer stress. • A warm line, Recovery College, and peer support can all help people with lived and living experience (PWLE) connect with others who know what they are going through.
Hope (Guidelines dimension 1)	• Using peer support can provide hope for those with mental illness. • Share recovery narratives and use hopeful language. • Reframe setbacks as learning opportunities.

Identity (Guidelines dimensions 4)	• Appreciate how the environment often dictates our identity. • While PWLE are often identified by their diagnosis, that is not who they are. • Recovery-oriented programming (e.g., Recovery College) can transform a person's identity into that of a student, artist, musician, etc.
Making sense and finding meaning (Guidelines dimension 6)	• Meaning and purpose may look different given people's various experiences or challenges, but that's okay. • Many people leverage their lived experience and share it with others because they know how difficult mental health concerns can be. • PWLE are not "broken," and it is not a professional's job to "fix" them.
Empowerment (Guidelines dimension 2)	• Being able to choose and have access to evidence-based interventions is important. • There is a need to acknowledge the residual custodial care model that is often found in mental health care. But it is still possible to challenge policies and practices that further divide the power imbalance between service users and providers. • Acknowledge and challenge the use of coercive practices such as restraints and seclusion. • Recognize that PWLE are experts by their experience.

As a resource, the Mental Health Commission of Canada's (MHCC's) *Guidelines for Recovery-Oriented Practice* (Guidelines) are a comprehensive account of recovery supports; however, their practical implementation into service delivery can be a challenge. The CHIME Framework overlaps with the various dimensions of the Guidelines[1] and can offer a practical working definition of recovery.

Recovery-Oriented Training

Recovery-oriented training involves the development of skills by using practical tools, programs, experiences, language, and documentation within a service context. While things like language may be constant across organizations, other tools (e.g., recovery assessment tools, access to recovery college, or the documentation interface) may differ for each service provider. To fully train providers in how to support personal recovery, it is important that organizations take an inventory of the tools and recovery-oriented programming available either within their services or in the community. Training may include:

- Recovery-oriented de-escalation techniques or crisis intervention planning
- Recovery assessment tools or assessments of activities in daily living, etc.
- Personal recovery goal setting
- Psychosocial rehabilitation competencies

[1] As indicated in parentheses in the table above.

- Specific recovery-oriented service delivery
- Wellness recovery action planning

Training exercises should include an experiential component that enables mental health professionals to practice administering, for example, personal recovery outcome measures to develop collaborative goals. Professionals can also pose reflective practice questions from the Guidelines to one another as a means for discussing enablers and barriers of recovery-oriented practice.

Co-Production

Co-production involves recognizing stakeholders such as PWLE and care providers as valuable assets in helping to transform services.[ii] Service users' experience, both within the mental health care system and their lived experience of mental illness, helps create the education and training content and inform its delivery. It is important to also involve the service providers (i.e., mental health professionals) who will receive the training and whose practice will be informed by the implementation. Including relevant stakeholders makes it possible to more fully grasp the individual and collective values, interests, and contextual factors that can help or hinder the implementation process.

Regarding education and training, interviews with PWLE and their families can help service providers identify practical examples related to the CHIME Framework and the Guidelines. For example:

1) What does hopeful language sound like?
2) What makes you (your loved one) feel connected to others?
3) What are you most proud of?

Questions can also be more general:

1) What makes you (your loved one) feel really good when receiving mental health care services?
2) What can staff do to support you (your loved one) to feel good?
3) What do you wish staff knew when providing care to you (your loved one) or others?
4) What barriers to recovery-oriented care do you see?

Information from these interviews can be used to illustrate CHIME Framework elements with real-world examples. It is also beneficial to hear the recovery journeys of PWLE first-hand through the services being provided, so professionals' sense of therapeutic pessimism can be challenged. Because professionals often see PWLE when in crisis or unwell, they may tend to generalize or limit a person's potential for recovery based on that experience. Hearing a first-hand recovery journey from within one's own services can therefore be beneficial.

Recovery is a lived experience discipline[iii] and as such should be taught by PWLE. Research has found that adding experiential components to training, such as role playing and using facilitators with lived experience, can increase its impact.[iv] Education and training that are co-produced and co-delivered by practitioners and peer support workers, for example, can illustrate a real-life partnership between professionals and PWLE while strengthening empathy and minimizing paternalistic practices.[v]

The table below provides an overview of main components of recovery-oriented education and training.

Input	Output	Co-Production	Enhanced Outcome
Education	Recovery knowledge — 1) CHIME Framework and 2) understanding the distinction between personal and clinical recovery	Stories/Examples from PWLE	Belief that recovery is possible
Training	Skills; application of knowledge in organizational/service context	Co-delivery of training with PWLE	

Considerations

While this resource provides some suggestions for co-developing recovery-oriented education and training, it will not result in an absolute transformation of services. Such education and training need to coincide with

- the implementation of the necessary strategic vision, leadership commitment, and resource allocation to allow recovery-oriented practice to be sustained
- job descriptions that outline recovery-oriented practice as core job functions for all staff
- ensuring the recruitment and selection of individuals who are open to learning how to deliver mental health services in a recovery-oriented way — sharing power and supporting positive risk taking[vi]
- performance management strategies[vii] that put leadership and staff on the same page in terms of positioning personal recovery as an important aspect of service delivery.

[i] Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. *British Journal of Psychiatry, 199*(6), 445-452. https://doi.org/10.1192/bjp.bp.110.08373

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[iv] Jackson-Blott, K., Hare, D., Davies, B., & Morgan, S. (2019). Recovery-oriented training programmes for mental health professionals: A narrative literature review. *Mental Health and Prevention, 13*, 113-127. https://doi.org/10.1016/j.mhp.2019.01.005

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[vi] Schwartz, E. (2020). *Promoting a recovery-focused workplace: Getting the right people in the door.* Community Technical Assistance Centre of New York and Managed Care Technical Assistance Centre of New York. https://ctacny.org/sites/default/files/Getting%20the%20Right%20People%20in%20the%20Door%20-%20Recovery%20Focused%20Organizations%20final.pdf

[vii] Schwartz, E. (2020). *Promoting a recovery-focused workplace: Getting the right people in the door.*