ImROC.

ImROC Sharing Experiences - Paper 1

The Development of the Ontario Shores Recovery College

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Introduction

Since the idea of 'Recovery Colleges' was first introduced in 2006/7, they have been taken up widely both across the UK and in many other parts of the world. Increasingly Recovery Colleges form a core part of recovery focused mental health services: they both embody the recovery-focused transformation of services and drive broader organisational change across services.

Over the last decade and a half, we have learned much about the core principles that underpin Recovery Colleges, but we have also learned that realising these key principles in practice can be challenging (see Perkins et al, 2018). The six core, defining, principles developed do not, and should not, constitute a prescriptive 'blue-print'. Instead, they provide a framework for local creativity and ownership: exploring different ways of realising the key ingredients in new and different ways in response to local ingenuity, opportunity and circumstance.

Recovery Colleges are dynamic, creative entities: continually growing and developing based on the ongoing process of local co-production on which they are founded, and learning from each other's experience. In order to facilitate the sharing of experience that is so important in fuelling development, ImROC will be producing a series of papers exploring different facets of Recovery Colleges and the realisation of the principles on which they are based in different contexts.

This is the first in a series of papers which will address, for example, how Recovery Colleges can genuinely serve the diverse communities of which they are a part, how they can respond to a changing landscape such as the mental health transformation agenda in England and the development of Recovery/Discovery Colleges for young people. In this first paper of the series, colleagues describe the development of a Recovery College within the Ontario Shores Centre for Mental Health Sciences: a specialist mental health service that supports people with complex mental health challenges provided in some 350 inpatient beds and over 90,000 outpatient appointments every year. This paper provides an excellent insight into the creative and thoughtful ways in which the core principles of a Recovery College were realised in practice in a largely clinical mental health service as a core part of a broader 'Recovery Action Plan' designed to make the whole service more recovery-oriented.

We were particularly impressed with the solid basis of co-production drawing together the experiential expertise of people who have used services and their families and the professional expertise not only of clinical staff, but also of other subject specialists within the service like the Environment Services and Communications Team. The ways in which the team addressed challenges that they experienced, made the most of opportunities that were presented, and ensured that the Recovery College is a core part of the mental health service that drives change in the broader service, is impressive. Equally important is their commitment to a continuing process of development. As the authors say: "There is little doubt that the implementation of the Recovery College has impacted the status quo of service delivery. By modelling co-production and offering training in co-production, the Recovery College has inspired its implementation elsewhere … It hasn't been easy, nor do we believe that our journey is complete, but we have learned many lessons." In this paper, the Ontario Shores Recovery College Team share some of these lessons.

One of the key principles of Recovery Colleges is that they are "integrated with their communities and with the mental health services and form a bridge between the two" (Perkins et al, 2018).Learning from the ways in which Ontario Shores have achieved this is likely to be of value to other Colleges.

As in many mental health services, the concept of a Recovery College was completely new to many working within the Ontario Shores Centre for Mental Health Sciences, and many of the principles ran counter to established ways of working. The concept was introduced to people working in the service via an innovative series of 'Recovery 101' seminars designed to discuss what a Recovery College is, and what it is not, and address the concerns of staff. The time taken to introduce the concept within the service, and involve others in its development, undoubtedly contributed to its success and the subsequent influence that it has had on the wider system. This influence can be seen not only in terms of promoting a recovery-orientation, recognition of the value of lived experience and co-production more widely in the service, but also in and in terms of staff job descriptions and the recruitment of new staff across the organisation.

Recovery Colleges established by and within mental health services can become isolated from the communities they serve. Aware of such possibilities, the Ontario Shores Team actively built partnerships with community agencies and organisations including local Public Libraries, Art Galleries and Universities and Colleges in the area. They illustrate how being both embedded within mental health services and in the local community can actively form a bridge between hospital and community for people using the services. They describe how, "for those who may not otherwise feel comfortable attending a session in the community alone", some courses initially start within the hospital and then move into the community: "The Recovery College often serves as the first brave step students are willing to take in their journey. Students often learn to trust the Recovery College's peers, students and facilitators. Because of the linkages between

the Recovery College and the community, our students are more open and willing to working with our partners. We find this transfer of trust to be critical in enhancing community integration." They also describe how, as a consequence of the community links, they have "observed community members coming to learn about how to be a good neighbour and support someone with mental health challenges."

We would like to thank the Ontario Shores Recovery College Team for generously sharing the lessons they have learned from the development of their College and the ways in which it has driven forward recovery-oriented change across the wider mental health service. We are sure that their insights and experience will provide food for thought and useful ideas for other Recovery Colleges across the world.

Rachel Perkins, *ImROC Senior Consultant*

Background

The desire to transform mental health services and position personal recovery as a key driver is as strong in Canada as it is in other parts of the world. The Mental Health Commission of Canada published its pivotal "Guidelines for Recovery-Oriented Practice" in 2015 (MHCC, 2015). Since then, there have been numerous opportunities for Ontario Shores Centre for Mental Health Sciences (a specialized mental health hospital), to translate this knowledge into practice. It hasn't been easy, nor do we believe that our journey is complete, but we have learnt many lessons. This paper aims to share our recovery journey as a mental health hospital that has been operational for over 100 years. In particular, it focuses on the role that our Recovery College has played in driving forward recovery-oriented practice across all services and professional groups.

Ontario Shores Centre for Mental Health Sciences (Ontario Shores) is a specialized mental health hospital located just east of Toronto, in Whitby, Ontario Canada. The hospital has approximately 350 inpatient beds and over 90,000 annual outpatient visits, supporting people with complex mental health conditions. In 2015, Ontario Shores sought to align its services more formally with a recovery orientation and began the implementation of a multi-year (and still ongoing) "Recovery Action Plan." This action plan included a team of leaders, front line clinicians, peer support workers and individuals with lived experience to come together with a project manager to guide the implementation of recovery-oriented initiatives. Our Recovery Action Plan team has two co-leads: a director from the hospital and a someone who has used our services.

At the time, the MHCC Guidelines had just been published, so we relied heavily on ImROC briefing papers to help guide our journey.

One of the biggest steps in our journey was the implementation of the hospital's Recovery College (RC). In 2023 there are approximately 30 RCs across Canada (Ontario Shores has assisted in the launching of at least a dozen of them through many partnerships with the Canadian Mental Health Association, National). However, in 2016 there was only one – in Toronto - which was devoted to improving recovery outcomes for individuals with housing difficulties. We undertook a site visit and armed with the published literature on recovery colleges, we embarked on the development of a RC at Ontario Shores.

The senior leadership team trusted our Recovery Action Plan team to prepare the organization for something not only had most staff never seen; but that most staff had never heard of. We knew the background, purpose and defining features of RCs established by ImROC would help (see Box 1) but at that time, we wondered if it was possible to transform the risk averse culture such as that of a hospital to one that could embrace strengths and self-determination, co-production, patient-driven education and blurring the lines of 'us' and 'them.'

Our senior leadership has prioritized Recovery as a goal for service delivery. As a hospital, we strive to make Recovery a vision and even include it in the hospital's tagline – Discovery. Recovery. Hope. As a further commitment to our hospital's cultural evolution, we began to work with ImROC in 2020, to review our progress and consider

the opportunities to drive Recovery forwards across the organisation as a whole. For this purpose, we focused on the ImROC RC defining features (see Box 1) as a structure to guide this work. In the sections that follow, we describe our successes, challenges and learning (see also Arbour & Stevens, 2017).

Box 1 **The ImROC Recovery College Defining features** (see Perkins et al, 2018).

1. They are based on educational principles and do not replace formal individual therapy or mainstream educational opportunities.
2. Coproduction, co-facilitation and co-learning lie at the core of their operation: they bring together lived/life expertise with professional/subject expertise on equal terms.
3. They are recovery-focused, and strengths based in all aspects of their functioning. They do not prescribe what people should do but provide a safe environment in which people can develop their understanding to keep themselves well and build skills and strategies to live the lives they wish to lead.
4. They are progressive, actively supporting students to move forwards in their lives both by progressing through relevant courses that enable them to achieve their identified goals, and by identifying exploring possibilities outside services where they can move on in their lives and work.
5. They are integrated with their community and with the mental health services and can serve as a bridge between the two: serving as a way of promoting a recovery-focused transformation of services more generally, creating communities that can accommodate mental distress and assist individuals to access and thrive in community settings.
6. They are inclusive and open to all. People of different ages, cultures, genders, abilities and impairments, lesbian gay and transsexual people as well as to people in local communities who face mental health and emotional challenges (and long-term health conditions/physical impairments), people who are close to them and people who provide services that include those with such challenges. By learning together on equal terms, in conditions where stereotypes are challenged and people can get to know each other, barriers can be broken down and genuinely inclusive communities promoted.

PRINCIPLE 1 RCs are based on educational principles rather than health service principles (e.g., they are students not patients, they register for courses of their own volition rather than being referred, they choose courses that they are interested in rather than being prescribed certain courses, they graduate rather than being discharged).

In the traditional mental health hospital, “patients” are told what they need and where to go. Staff believe their role is to ‘fix’ people and people using services expect staff to provide answers. Challenging this notion that professionals know best, can be difficult. In the beginning, we wondered how we might be able to bring staff and people using services together to design and lead courses in respectful and equalising relationships when neither group had heard of either recovery colleges or coproduction before.

Members of the Recovery Action Plan team ran a drop-in education seminar we called “Recovery College 101.” It was open to staff, families and patients and it had one goal: to explain what a RC is and is not. We used ImROC’s defining features to outline our presentation These stimulated detailed discussions and many questions, for example: “How are we supposed to document patients’ progress in their charts if there isn’t a referral for the service or any feedback to staff?”

"We already have a Treatment Mall – how is this different?" It was very clear that mental health professionals found it difficult to comprehend that the RC would not offer treatment, nor would it replace treatment. It was also clear that this new model did not adhere to the conventional systems of the hospital.

The questions we were asked helped us to clarify our own ideas and drove us to find ways of facilitating understanding about the proposed RC. To address confusion about the difference between education and treatment, we highlighted parallels between existing educational experiences for people with mental health conditions and those of the RC. For example, people with mental health conditions were invited to attend Grand Rounds (research presentations) within the hospital, which were offered every Thursday on a variety of mental health and research topics. Staff may not have been aware that people using services attended Grand Rounds and no documentation was required as attending grand rounds is education, not treatment. We tried to illustrate that attending a course in the RC was similar. People using services register for courses in the same way as they would in an external college, as a student who makes choices about what and when to study. Therefore, when the RC team is contacted by clinical staff asking how a particular person using services is doing in the college, we do not speak on behalf of the student but suggest they ask the student themselves.

We also made the distinction that if a course was needed to help students understand treatment options, it would be learning about Cognitive Behaviour Therapy (CBT), not receiving CBT. (As it turned out, one such course was eventually co-produced and was found to be extremely helpful in demystifying the CBT, DBT, and trauma services offered within the hospital). The questions and challenges from clinicians helped us to grow our ideas and built our understanding; they were also essential in gaining support and understanding of staff. We ultimately offered Recovery College 101 twelve times during the summer of 2016, before launching our first co-produced and co-delivered courses in the Fall.

We now offer more than 40 courses in the RC. All of these are based on nominations, suggestions and ideas from students, all of them support students' recovery and none of them duplicate courses available in the local community colleges. Courses cover a variety of topics ranging from *Budget Bites – Eating Well on a Budget to Finding your Voice: Putting Pen to Paper.* One course in particular is worth noting – *Course Facilitation Skills Training (CFST).* This course is designed to provide potential course facilitators with the knowledge and skills related to educational principles, classroom presentation and discussion facilitation. This course was coproduced by peer trainers working with Ontario Shores vocational services and a local community college. We have shared the content of the course with many other RCs across Canada who wish to co-develop similar content.

Important learning and potential challenges included that:

- All courses need to offer a variety of different learning styles to meet the various preferences and needs of the students. Whilst it is essential to provide information from the perspective of subject expertise, professional expertise and experiential expertise, it is also necessary to make space for more open, discussion-based learning where students learn from one another and often take hope and practical tips from others with shared experiences Fewer slides in a session doesn't necessarily mean less learning.
- Consideration needs to be given to the words that we use. The Recovery College needs to be fully accessible, so it is necessary to use non-medical/jargon terms, no acronyms and maintain clarity and consistency. For example, the RC offers courses, not "groups." In the hospital context, language can easily revert to clinical speak, because we are all more accustomed to that.
- We have found that we need to ensure the differences between community college and the Recovery college are clear. Some individuals have had negative experiences in college, so letting them know they can achieve success in the RC despite those experiences was important. Also, students able to attend mainstream education and wanting to achieve educational qualifications are signposted towards these courses – for many attending the RC is a useful first step in getting back into education.

PRINCIPLE 2 Co-production, co-facilitation and co-learning lie at the heart of an RC's operation.

We have worked as a team of people with experiential, professional and subject expertise, valuing the input of all members of the group equally. This has been a helpful way of modelling coproduction, demonstrating the added benefits of listening to lived experience, showing staff and potential students that people 'like them' are respected and offer value precisely because of the struggles they have lived with. Our first success in coproduction came in early 2015, when two of our forensic team members attended a conference presentation about a RC offered, at a high security forensic facility, in the United Kingdom. These clinicians were so inspired by this work, they immediately wanted to determine whether co-produced courses could be delivered within our hospital. The two clinicians created a pilot study to see if it was feasible to develop co-produced courses within the forensic program. They worked with people with lived experience and members of the vocational services team to create what is now the Course Facilitations Skills Training (CFST) Course (the course that was eventually revised and discussed in Principle 1). This program introduced the idea of creating co-produced courses with and for people receiving services on forensic units. They then collected ideas from those individuals about what courses they would like and worked together to build these into proposals. Proposals outlined a description of a course they would like to attend/lead, its learning objectives, and any resources, supplies or audio visuals needs. Subsequently, six courses were offered over a thirteen-week period and included topics such as: Healthy Relationships; Fitness Education and Activity, Spirituality, Wellness Recovery Action Planning (WRAP), etc. This small team were able to demonstrate the proof of concept – that individuals receiving services within a mental health hospital were interested in co-developing courses and co-facilitating courses. People with mental health conditions were not "too sick," "not motivated," or "lacking insight."

From this experience, we have been able to identify some of the enablers and challenges to introducing co-production of courses at the hospital. This was the catalyst in the development of the RC at Ontario Shores (Martin, Stevens & Arbour, 2017). What is more, one of the forensic clinicians (and author of this paper AS) moved from her forensic nursing post to become the leader of the Recovery College at the hospital.

We have learned a number of lessons when reviewing our progress with regards to this principle including:

- That ongoing evaluation of the courses is crucial for quality assurance. We established the *Quality and Evaluation Committee* comprising students, trainers, peers and researchers. This group comes together every semester to review proposed courses and ensure they are fully coproduced and demonstrably in line with RC principles. To support this process, we simplified the course proposal process to just two questions: 1*) What will we do?* and *2) What will we learn?*
- that co-facilitating can be more time consuming and challenging than simply delivering training alone. Both the staff members and PWLEs need time to discuss options, share differing views, negotiate a course proposal, plan content together and co-deliver. Support and guidance need to be available.

Co-production has since become an organizational priority and it is now recognised that it can take more time and therefore may require more resources and commitment.

The practice of co-production is catching on in other parts of the hospital. Our Communications Department has been a big proponent of incorporating PWLE in a variety of their projects. Of note, our Annual Report consistently includes patients' voices in co-designing the content of the report as well as sharing recovery journeys (see Chelsea's story https://www.ontarioshores.ca/chelseas-story-0).

Interest from staff groups in assisting in co-developing and co-delivering courses with our peers and students has also emerged. For example, a member of our communications team who had a passion for photography worked with one of our peers and students to offer a photography course in the RC. In addition, a staff member who used martial arts as a wellness tool in his own life co-developed a course with the support of his supervisor. The course was offered

to students who were interested in enhancing their knowledge and practice of martial arts as part of their recovery.

Another example is our environmental services (EVS) team who noticed that individuals who accessed services within the hospital continually asked questions about their roles and practices within the hospital. Because the services users were so interested in the hospital practices related to maintenance, sanitation standards, etc. the EVS team decided to gauge interest in co-developing a course to teach students about the hospital standards and practices as they related to environmental services. The individuals accessing the services within the hospital were able to undertake the course and practice some of the skills whilst they were inpatients. They shared how empowering it was to share the responsibilities on the units and learn new things. As such, this course provided students with skills that they could add to a resume if they wished to pursue work in environmental services. (See course description below.)

Box 2 **Environmental Services**

Environmental Services Skills

What will we do?

Are you aware that there is an established way to clean properly? Would you like to learn cleaning skills that you can use in your daily life or put on your resume to help you obtain a career in Environmental Services? If so, then this is the course for you!

What will you learn?

- Overview of duties and tasks of an Environmental Service Worker
- Proper use of housekeeping carts and equipment
- Safe working habits and musculoskeletal disorders
- The 3 moments of hand hygiene for an Environmental Service Worker
- Introduction to chemicals and safe usage
- The essentials of cleaning and methodology
- The modes of transmission
- How to clean floors safely
- Waste management
- How to properly plunge toilets

Co-production is not always easy, and it does take time, but it also yields a more valuable outcome because it brings the additional contribution of experiential expertise. Often, we find that as professionals within the mental health system, we assume that we know all the answers but unless we have used services, we often don't even know the questions. Co-producing with people who use services alerts us to routine clinical practices that can be excluding and unacceptable; introduces us to new ideas and alternative ways of doing things born out of being on the receiving end of services. We need to slow down and work with people who have lived experience of the course subject so we all fully understand issues/ phenomena in context and from different points of view. When we do this, we can develop effective solutions and projects that meet more needs, and which are likely to garner a desired outcome.

PRINCIPLE 3 RCs are recovery-focused, and strength based in all aspects of their functioning.

Working in a mental health hospital, we routinely become caught up in some of the structurally stigmatizing practices that govern health care. For example, health care practitioners are often guided by ideas of what an individual *can't* do. To access certain benefits, individuals are often asked to outline their deficits and the ways in which they are "disabled." This process limits individuals' belief in their own potential and may even serve as self-fulfilling. RCs are nothing like this. RCs are all about possibilities. We are fortunate enough to hear how life changing the RC has been for people who felt they had exhausted all options of mental health services and had been told they were "treatment resistant". What we find most gratifying, is that there are times when people have come across the RC as a last hope and tried something new, like an art class, having never engaged in it before; and then realized they identified as an artist, not "treatment resistant". Thus, art becomes a conduit for recovery (see Mike's story: https://www.ontarioshores.ca/suicide-grief-mental-illness-and-recovery-through-art).

In addition to knowledge and skills that are learned in the RC, we also expect our students to experience an enhanced sense of personal recovery. From a theoretical perspective, we find the CHIME framework (Connection, Hope, Identity, Meaning and Empowerment) of recovery (Leamy et al., 2011) aligns closely with the outcomes we hope our students experience.

Connection – whether online or in person, we've seen the ways that the RC connects individuals. Like most RCs around the world, we had to pivot to position courses online in response to the pandemic and whilst we chose to cap enrollment on virtual courses to 15 students, in order to ensure meaningful engagement and connection among participants; and reduced the number of courses we offered per semester (from around 50 to 10 – 12), we were left in no doubt that the RC served as a lifeline during the pandemic and kept people in touch and informed.

We have seen students build connections that have extended far beyond the walls of the RC. The college creates the sense of community, but it is our students who continue these relationships in their everyday lives. For example, students keep in touch and support one another to attend classes. They use their own Facebook groups to communicate. They meet up between courses and make the sorts of friendships that we all make with fellow students at college (but are perhaps less likely to make with other 'patients').

Hope – Too often people using mental health services feel that there is no way forward, they assume - or they may have been told – that they may never work, that life will be difficult, that they have exhausted all options. In stark contrast, the RC exudes hope. A lot of this energy has to do with connecting with Peers. Our Peer Trainers believe in the potential of every student coming to the college, they are encouraging and open in sharing their own experiences – successes and the challenges. During courses, students meet others who share their experiences and see that they are now in work, driving, looking after children or co-facilitating courses. This helps students see that while there may be challenges, others have navigated some of the same experiences and found ways through, they can provide hope and encouragement, reinforcing the idea that setbacks don't have to be defeating. The RC intentionally meets people where they are – encouraging small steps and recognizing the non-linear and extremely personal nature of recovery. In uncertain times we may have to hold the hope for students until they are ready to take it for themselves. One of the strengths of the RC is there is no 'one size fits all' measure of success.

Identity – In reading Mike's story (included above) it is apparent that the transformation in identity from a diagnosis or someone who is "ill," to an identity that is much more satisfying such as an "artist," can be profound. If you think about the ways in which Western culture conceptualizes "mental patients" it's not difficult to see why this identity does not serve anyone well. The shift in identity from that of "mental patient" to "student" or "course facilitator" means that experience of mental health challenges becomes a source of pride, rather than a sense of shame.

The RC has a number of learners who have previous professional experience including teachers, project managers and even university professors. The RC offers these learners an

opportunity to regain a piece of their identity that they may have lost due to their illness through their role as trainers and educational experts in the RC.

Meaning – By participating in the RC, students can learn and recognize that they are not alone. Often their learning and development does not come from the subject matter they are taught but from the relationships that they build with other students. It is in peer-to-peer conversations that they begin to make sense of experiences and find new meaning. Often, students are exposed to something new that becomes important. The RC provides students and facilitators with opportunities to explore personal purpose and passion; often identifying new purposes/ passions they didn't even know were there.

The RC allows individuals to explore subjects and topics that help them to make sense of their lives and experiences. In a recent course about healthy eating a student researched and shared all local community resources regarding food security. In addition, she has identified that this is a topic she feels passionate about and wants to help others.

Empowerment – Recovery narratives often include the experience of taking control of one's own path to wellness. Rather than relying on the expertise of clinicians to guide individuals, RCs position the learner as the expert. They are the expert by experience and as such, are best placed to choose their own path and their own experiences. Learners select their own courses and determine how they are going to engage with the content. Our peers support and deepen the learning by taking the student's lead based on their learning goals. In addition, students are empowered to share aspects of themselves and their journey with others.

PRINCIPLE 4 RCs are progressive – actively helping students to move forward in their lives, working towards personal goals, and/ or to overcome personal challenges.

Traditional mental health services focus on what is "wrong" with the individual. Many times, a diagnosis of a severe mental illness brings a bleak and pessimistic prognosis, focussing on what the individual cannot do as a result of their mental illness. It would then seem to be difficult for individuals with mental health conditions to see themselves as anything else – a diagnosis with limited potential. This is where the RC is different. It positions the student in the driver's seat ready to embark on possibilities. We are always pleased when we hear about students who had previously been told they were too unwell to participate, finding their own paths and gaining confidence. We have heard many times how students' core beliefs about themselves begin to change – they now see themselves as having much to offer.

The RC at Ontario Shores offers several courses in a variety of areas. There are courses on wellness, skill development, self-discovery, and on educational topics that are of interest. Unlike standards-driven manualized therapies or treatment (which usually offer a one size fits all approach), RC courses offer so many options. This affords students the opportunity to build on the foundations they create. Students have the opportunity to create Individual Learning Plans (ILPs) to identify any adjustments that might help them learn, identify their goals and select courses that might help to achieve these, and to track their progress towards these personal goals. Thus, student progress is customised and self-determined. This is unlike anything else offered by the hospital.

The RC in the hospital setting enables students to play an active role not only in accessing courses, but also in developing the courses. Through co-production, students play an active and equal role in shaping the possibilities within the college. Even further, there is the possibility to co-facilitate.

PRINCIPLE 5 Recovery Colleges are integrated with their community and with mental health services and form a bridge between the two.

Over the past 100 years that our hospital has been operational, it has seen the evolution of the community that surrounds it. What once was farmland and fields has turned into a diverse and dynamic part of the Greater Toronto Area. As such, our community has much to offer. Nonetheless, upon inception of the RC, we fell into the trap of offering the courses within the four walls of the hospital. Although we made use of our beautiful hospital grounds, the RC did not necessarily represent the bridge between hospital and community. We still felt the effects of a risk averse culture, and our hospital was quite insular; because of this, our team lacked experience forming and promoting community partnerships. In our experiences working with, and conducting fidelity assessments in our own, and in other Canadian RCs, we have found this principle the hardest to implement (Battistelli, Leroux & Arbour, n.d.).

As the RC community became better connected, we joined national and international communities of practice (COP) of known RCs. Internationally, we went to our first COP meeting at the University of Boston in 2016. It was at this meeting, we were acquainted with RC leaders from Australia, France, Italy, Denmark and the United States. We learned from each other and shared successes and challenges. A few years later, we were approached to join an emerging COP out of the Canadian Mental Health Association (CMHA) Winnipeg. Like us, CMHA Winnipeg had researched RCs using many of ImROCs resources and expertise. In addition, we were fortunate enough to attend an in-person meeting in Winnipeg in 2020, where Julie Repper supported all new RCs in Canada to adhere more closely to the fidelity criteria and core principles. It became apparent to our team that we needed to spread our RC beyond the walls of the hospital – that we weren't serving our students well by creating a dependency on Ontario Shores.

It was shortly thereafter that we made concerted efforts to enhance our college's community integration. In particular, we began working with the Oshawa Public Libraries to offer a course on-site and in the library. In these library workshops, students learn about resources available in the greater community. We are finding that the RC is a low barrier means of accessing information that students may not have sought out otherwise.

We found additional opportunities to partner with the community. Tai chi offered at the hospital initially and then in the community, builds comfort for those who may not otherwise have felt comfortable attending a session in the community alone. In addition, we now liaise with local art galleries, Abilities Centre, community mental health agencies, etc. We find that this not only creates integration within the community but it also sends the message of a shared commitment to wellness among community partners. The RC often serves as the first brave step students are willing to take in their journey. Students often learn to trust the RC's peers, students and facilitators. Because of the linkages between the RC and the community, our students are more open and willing to work with our partners. We find this transfer of trust to be critical in enhancing community integration.

PRINCIPLE 6 They are inclusive and open to all.

In general, we tend to see more participation among individuals who access outpatient services from the hospital compared to those who access inpatient services. To address this, we try to raise awareness of the courses within the hospital. We deploy our peers to the units to educate staff and those accessing services about the courses in RC. While there, the peers sit down and meet with individuals to find out about goals they are working on and whether there are any courses in the RC that can support the attainment of those goals. Staff often accompany those accessing inpatient services to their courses and provide feedback about how helpful and informative the courses are. This has increased the appetite for staff to take more courses within the college.

In the evolution of our RC, this principle continues to be a work in progress. While the culture and environment within the RC courses is extremely welcoming and inclusive, the notion that courses are open to all (or at least attended by all) is a challenge. Since its inception, the majority of attendees of RC courses would likely identify as those who receive (or have received) mental health services. While the courses are theoretically open to all, we have yet to see significant uptake among our hospital staff and family/caregiver courses. As a result, we made some developments.

Courses for Family Caregivers

Family caregivers play a critical role in supporting the recovery journey of their relatives, yet there is limited research examining how to support their own well-being, as well as the strengths and resilience that they carry. Many caregiver support groups allow participants to share their caregiving 'stories' amongst peers. This provides many benefits (e.g., better coping, building resilience, reducing negative feelings by focusing on the positive aspects of their roles), however, simply sharing experiences does not offer holistic support nor does it effectively address caregivers' needs. Family caregivers have their own recovery journeys which need to be explored. Attention and focus on RC curriculum for caregivers of mental health and brain conditions was long overdue. Responding to this gap in practice and support, we have made concerted efforts to evolve the RC course offering to include topics that would attract caregivers.

The "We-Care-Well" Series was a novel initiative developed and facilitated by staff members with lived experience as family caregivers at Ontario Shores, and was first offered through Ontario Shores RC, during the Winter and Spring Semester in 2023. The workshop series offered family caregivers at Ontario Shores and local communities the opportunity to recognize, and to support their own well-being by exploring the CHIME Framework and their own recovery journeys. To our knowledge, this is the first co-developed initiative that focused on personal recovery for family caregivers in the mental health setting in Ontario. In total, 12 family caregivers registered in 2 inaugural workshop series. Seven virtual workshops were held via the secured videoconferencing platform *Zoom*. The 3 key objectives of the series were:

- Learn about recovery-oriented principles to promote and reinforce self-care, resilience, and strengths as family caregivers.
- Understand how to leverage recovery perspectives and principles to navigate around, or even navigate "through" challenges and barriers within the caregiving role.
- Share practical, actionable skills and strategies that support mental health as caregivers.

The first series of three workshops was delivered during the Winter 2022 Semester. As part of the content co-design process, the six registered participants were encouraged to share their caregiving stories to promote peer learning and support. Participants then had the opportunity to safely practice different self-care approaches through role-playing real-life informed scenarios. The second workshop series consisted of four workshops. Building on recovery-oriented principles explored in the first workshop series, the second series continued to provide family caregivers a safe environment to practice different communication strategies e.g., non-violent communication model (Rosenburg, 2015) and compassionate caregiving. Family caregivers also worked with Bioethicists to become familiar with the Mental Health Act, and to become more empowered to advocate for themselves and their relatives. Participants also immersed in creative activities - Photovoice and Storytelling - to find their voice as family caregivers and were encouraged to share their recovery journeys using these tools.

Through this work we observed that:

- Our Caregiver Recovery workshops are very different from existing caregivers support groups.
- Didactic learning was kept to a minimal so that group dynamics and direction of the discussions may be driven by the participants themselves, while the facilitators actively listened.
- By incorporating their own unique needs, experiences and insights into the discussions, caregivers moulded the workshop activities and future content in ways that were meaningful for them.
- Cohesion and rapport amongst participants were strong as they shared their struggles, strategies that they have attempted and resources they have tapped into.
- By hearing about how a fellow caregiver navigates through a similar challenge and witnessing resilience in others, hope was instilled.

Another poignant observation from this series, is that caregivers tended to prioritize the needs of their care recipients before their own. Many workshop participants tied their understanding of 'recovery' to seeing their loved ones in a happy and prosperous state, sometimes at the expense of their own self-care. Caregiver Recovery workshops will continue to provide caregivers the platform to explore their identity outside of the caregiver role, and their own needs for well-being.

In addition, attending the caregiver series seems to have served as an introduction to the RC. Since its inception, we have seen that individuals who take the caregiver series take other courses within the college. Caregivers take courses with their loved ones. We have seen many mothers and sons and fathers and daughters attend the various courses together. We also have observed community members coming to learn about how to be a good neighbour and support someone with mental health challenges.

Post-secondary education partnerships

The college has also extended its reach into non-mental health facilities, working with seven post-secondary Universities and Colleges across Ontario, Canada to assist in the implementation and evaluation of RCs for students, by students. The demand for co-produced, peer facilitated connection, mental health education and support is extensive within the post-secondary context. As a result, Ontario Shores has allocated peer and research/ implementation resources to assist in this endeavor in the post-secondary context. Ontario Shores is committed to partner with Universities and Colleges to build their peer workforces and introduce RCs to young adults grappling with unique mental health challenges while at school. We are hoping to continue this work to look at how RCs can help specific student groups such as International Students, the LGBTQ2S+ community on campus, graduate students, high performance athletes, etc. The RC has proven to be a low barrier means for students on campus to receive education and support that eases the transition from high school to post-secondary school, as well as the transition from adolescence to adulthood. This is evidenced by the fact that many of the co-produced courses in this context are focused on "adulting" and other "life hacks" than can minimize life and school stressors.

Working with Adolescent Services

In being 'open to all' our college has played a pivotal role in considering how to better engage with groups beyond providing workshops and courses within the college itself; playing an active role in challenging our thinking and influencing practices throughout the hospital.

With the inception of the RC at Ontario Shores came valuable experience with co-production and the amplification of the voices of individuals with lived experience. With the success of our RC and staff attendance to Recovery 101, came the realization that we didn't have devoted recovery resources for our adolescent units. What we also came to realise, was that we didn't really know if the CHIME framework necessarily mapped on to young people's recovery journeys.

With this question, came the opportunity to explore the adolescent recovery phenomenon by engaging our adolescents who accessed services within the hospital (we have two units). However, before any of the work began, our research team wanted to hire a lived experience co-investigator who had experience in the adolescent mental health treatment setting. This role was imperative as none of the research team was younger than 30, nor did we have lived experience of adolescent mental health challenges. Recruiting for such a position proved difficult, as job descriptions did not include lived experience as an asset at the time. This was something we wanted as a principle, but no role within the research department included lived experience. Luckily, a student application outlined her participation in an advisory committee, and we were able to ask her about it; hence learning of her lived experience.

The quality of the work was much enhanced by using a lived experience co-investigator to help us co-design the research methodology with the adolescents. This included modifying the language we used (adolescents don't like the word recovery) and the way we obtained consent (they wanted our pictures on the consent form, so they knew who we were). We learned a number of things that changed our perspective on adolescent recovery; but of note was that the adolescents felt their diagnosis was their identity when in hospital. We translated our findings into practice changes that recognise the fluidity of the adolescent identity and that staff needed to move away from focusing solely on the diagnosis. As a result, we started calling the adolescents "teens" (a word of their choosing) rather than "patients". We also learned that sometimes the teens wanted to be in charge of their own paths to wellness and sometimes they just wanted to feel like kids and to be taken care of. Both of which were important. (Please see Arbour et al., 2023) for additional findings. Our experiences using co-production in the RC translated significantly to the way in which we conducted this research and enhanced the quality of the findings and our knowledge translation. For example, when results from our adolescent eating disorder outcome study were presented at the hospital's Grand Rounds, it was the teens who made the presentation. There is no doubt that the ethos behind the RC made that possible. Since that time, patient-oriented research has become a priority for some Canadian research funders, namely the Society for Patient Oriented Research (Government of Canada, 2023).

The role of our Recovery College in transforming our workforce

It has been important for the organisation to recognise that, whilst the college can model recovery focused practice in the organisation, responsibility for transforming practice does not sit solely with the college.

Since launching our RC in 2016, we've seen the progress our hospital has made to support personal recovery as a focus of our service delivery. For example, to further advance this work, Ontario Shores has positioned a recovery metric (the Recovery Assessment Scale) as a performance indicator, launched *The Journal of Recovery in Mental Health*, and worked collaboratively with many partners, including the MHCC to co-author resources designed to advance recovery-oriented practice in Canada (see MHCC, 2021).

Introducing recovery metrics and new ways of working relies on a workforce that understands and appreciates the organisation's commitment to driving forward recovery focused practice and the role that they have to play.

A series of six workshops, focusing on each principle in turn, were facilitated by imROC colleagues and demonstrated the organisation's commitment and belief in the role of the RC.

As well as an opportunity for the college to review progress and consider how challenges might be addressed, the purpose was to sow seeds of recovery practice to others beyond the college, for individuals and services to recognise the role of Ontario Shores in an individual's recovery journey and how they might contribute to this through engagement with the college. They also provided a forum where we saw a growing strength in the voice of the peers and those who have travelled through Ontario Shores services.

Initially there was a sense from participants that the Recovery College held the bulk of the responsibility for a recovery approach within the organisation but as the sessions progressed, we observed an increasing sense of organisational responsibility. The format of the workshops provided opportunity to those who have used/are using services and those delivering services to share honest reflections to collectively move forward. At the end of each workshop participants were prompted to consider key questions around a specific defining feature e.g.

- What priorities would you choose to build on what you are already doing to ensure that your ***Recovery College*** is 'progressive' in all aspects of its functioning?

- What priorities would you choose to build on what you are already doing to ensure that ***Ontario Shores*** is 'progressive' in all aspects of its functioning?
- How might the Recovery College assist the organisation in achieving these priorities?

There was a shift in feedback from small group work from a more traditional response - 'we say and expect you to..' or 'you said, we did' approach, typical in organisations as we strive to respond to suggestions and complaints….to a far more dynamic 'we say and we will' approach; far more solution focused, collaborative and fitting well with our commitment to coproduction.

Staff Orientation (Induction)

In an effort to position the RC 'open to all' we wanted to see more hospital staff participation and attendance. To this end, our team co-produced a course about Personal Recovery for all new employees at Ontario Shores. While the MHCC's Recovery-Oriented Practice Guidelines were available, personal recovery is seldom taught in post-secondary nursing and other mental health-related programs in 2018. We now offer a course in the RC for anyone who wants to learn about personal recovery and recovery-oriented practice. This course also serves as training for new employees of the hospital. The objectives are simple. As a result of participating in Recovery 101, students will: 1) be able to distinguish between clinical recovery and personal recovery; 2) learn about ways to support personal recovery via the CHIME framework; 3) believe recovery is possible.

We measured the first and last objective by asking participants to define personal recovery and we administered the Recovery Attitudes Questionnaire (Borkin et al., 2000). Results of a pre-post participation comparison revealed that we accomplished our objectives as both recovery knowledge and attitudes increased. We have seen many students in the course come from within the hospital, from the community (even faculty from local universities and colleges) and family caregivers. This course was highly attended by all those who accessed services, service providers, caregivers and community members; demonstrating the power of the RC in positioning all voices and experiences at the forefront. We have received excellent feedback for this course. We continue to offer this course today.

Knowledge Mobilization Specialists and Recovery Plan of Care

Much has been published in the last twenty years regarding the positive evidence supporting recovery-oriented practice and now recovery colleges (see Bourne, Meddings & Whittington, 2018 and Thompson et al., 2021). We are fortunate to have a team of researchers and professional practice leaders within our hospital who are dedicated to translating this knowledge into practice. This year we have taken this pursuit a step further by identifying volunteer knowledge mobilization specialists across the hospital whose job it is to leverage recovery-oriented programs like the RC and integrate their use into the various programs and units. Our knowledge mobilization specialists represent managers, frontline nurses, peers, recreation therapists, quality improvement specialists, forensic staff and others. These staff have become ambassadors for recovery, including ensuring our RC is top of mind for staff and service user education. The aim with this work is to ensure personal recovery goals are identified by all individuals accessing services. In the past, recovery goals contained in the medical record were very generic (ie., "patient wants to go home"). We are leveraging the Team Recovery Implementation Plans (Repper & Perkins, 2013)

to inform teams of the resources available to them – both within their units and within the hospital and community. We are auditing the recovery goals of each of the units and programs every quarter, with the goal that at least 80% contain individualised recovery goals. We believe that staff will come to realise how the RC can become the bridge between the hospital and community and serve teams well in supporting goals that are deeply personal for those accessing services.

Human Resources and Getting the Right People Through the Door

Our hospital is over 100 years old, and much has changed over the years. In 2014, Ontario Shores was one of the first organizations to sign the Mental Health Commission of Canada's Declaration of Commitment to Recovery. The implementation of the RC has proven to be a catalyst of change in that regard. As part of our evolution to be more recovery-oriented, we came to realize that the RC brought about a different way to view mental illness. The RC challenged the notion that clinical staff always know what's best. This attitude has slowly trickled into the various units, challenging the traditionally custodial model of care.

When recovery became a central focus of our care model, we realized that we needed to attract leadership, nurses and allied health professionals who were open to a different way of doing things. Many new graduates from nursing aren't always familiar with mental health, let alone recovery-oriented practice. What we realized, was we needed to attract new hires that were open minded and highly empathetic. Perhaps they couldn't define recovery, but would they be open to trying new ways of collaborating with people with mental health challenges and supporting their goals and pursuits. Job descriptions and interview questions typically included clinical-based knowledge and competencies. However, these are things that can be taught on the job if needed. What we needed to ensure was that our employees brought was flexibility, interpersonal skills and the willingness to let the people with mental health challenges determine their own goals, even if we don't agree with them.

Some interview question included:

- In your practice, can you share how you have helped individuals accessing services recognise and value their own strengths?
- How do you see recovery as different or the same as treatment?
- How might you support an individual's deeply personal goals?
- How have you helped individuals accessing services become more involved with their communities and develop community relationships?

In addition to the modification of interview questions, we have also modified job descriptions for all nurses, clinical managers and allied health professionals. It is now an expectation that staff support the development and attainment of personal recovery goals. It is also an expectation that staff will learn about resources and tools that can help individuals accessing services achieve this – including being aware of the courses offered in the RC. To this end, managers now bring the RC team onto the units at the beginning of each registration period to inform both staff and service users of the courses available.

Learning and Development Opportunities

In addition to enhancing co-production within the hospital, we also endeavor to leverage the RC to realise its full potential. In addition to Recovery 101, we hope to establish the RC as a place where all can come and learn topics together. We believe that the college can serve as education for all but can serve as an innovative means of education and training for staff. Some ideas for courses that could benefit anyone but could train staff include: Establishing and Supporting Recovery Goals, Risk Assessments, How to Conduct Meaningful Co-Production, Equity, Diversity and Inclusion, to name a few. We have the lived experience and professional expertise to accomplish this. Positioning this content in the college challenges traditional training and education and brings the community together to learn the same things and be on the same page.

Conclusions and Future Opportunities

There is little doubt that the implementation of the RC has impacted the status quo of service delivery. By modelling co-production and offering training in co-production, the RC has inspired its implementation elsewhere (eg., communications, research, quality initiatives, etc.) As a next step, the organization endeavors to further embed the voice of lived experience by developing expertise to support meaningful co-design whenever possible. This is an ambitious goal, and not an easy one, however; our experiences with the RC have demonstrated that meaningful co-production is a worthwhile pursuit.

There have been considerable RC developments across Canada and abroad and we are proud that organizations now come to Ontario Shores to learn how to make personal recovery a priority and implement RCs to enhance this work.

We believe that all this work will lead to one of our biggest opportunities – transforming the mental health care landscape. Both the work we do inside and outside our walls pushes us toward this goal. The RC positions Ontario Shores to be excellent partners within the community. We can do this by ensuring our RC is the bridge from services to community partners. If done correctly, we can support the transition of people from mental health services to become more meaningfully integrated into the community and connected with others; and can better support them should they need to use our mental health services.

Community partnerships can lay the foundation for a recovery network aimed at not only supporting individuals' personal recovery but challenging inherently stigmatizing views of the limits and disabilities associated with mental health challenges. There is some way to go but as a hospital that is embedding recovery supports and values into our services, we cannot help but be optimistic as we reflect on our journey for this paper.

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Simone Arbour, Allison Stevens, Nicole Meens-Miller, Mary Chiu, Mark Rice, Jane Rennison & Waldo Roeg - 2024 - Sharing Experiences 1: The Development of the Ontario Shores Recovery College - Nottingham: Imroc.