RECOVERY
Hope Changes Everything

HOPE CHANGES EVERYTHING:

A GUIDE TO RECOVERY-ORIENTED SYSTEM TRANSFORMATION IN MANITOBA

Manitoba

TABLE OF CONTENTS

HOPE CHANGES EVERYTHING: A GUIDE TO RECOVERY-ORIENTED SYSTEM TRANSFORMATION IN MANITOBA

BUILDING MOMENTUM IN MANITOBA

Over the last several years, a great deal of work has been taking place in Manitoba to transform Manitoba's mental health service system to one that is more recovery-oriented. Research has shown that when recovery-oriented systems and services are offered to people with mental health problems and illnesses (PWLE) it leads to better health, social and employment outcomes, including reduced hospitalization and emergency visits, and increased likelihood of successful goal achievement related to employment and housing. People with lived experience, family and staff also show greater levels of satisfaction in recovery-oriented mental health systems.

In 2011, Manitoba released a five-year mental health strategic plan, *Rising to the Challenge*. A key pillar of the plan is creating a recovery-oriented mental health system, one which supports and emphasizes self-determination and self-management by those experiencing mental health problems and illness.

In 2014, the Provincial Recovery Champions Committee was formed to:

- provide assistance and advisement to Manitoba Health, Healthy Living and Seniors in the implementation of recovery recommendations stemming from the strategic plan
- champion recovery and recovery-oriented services throughout all regions of the province
- influence system transformation

One of the first pieces of work that the Provincial Recovery Champions Committee completed was the development of provincial definitions for recovery and recovery-oriented mental health services (see next page). In spring 2015, the Provincial Recovery Champions Committee distributed a provincial environmental scan on recovery-oriented services to collect baseline data that can be used for measuring progress in the future.

In June 2015, Manitoba Health, Healthy Living and Seniors, in partnership with the Provincial Recovery Champions Committee hosted Provincial Recovery Working Days to help inform the development of key success and outcome indicators for Manitoba's mental health system. Approximately 120 key stakeholders including representatives from the regional health authorities, mental health agencies, government departments, persons with lived experience, family and natural supports and other interested partners from across the province attended the working days. International recovery-orientation expert, Dr. Mike Slade was the keynote speaker and shared his expertise in system transformation and the development of recovery-oriented mental health services.

At the working days, the Manitoba Schizophrenia Society in partnership with Manitoba Health, Healthy Living and Seniors; and the Provincial Recovery Champions Committee launched a provincial video on recovery and system transformation. The video is a provincial educational tool that will foster discussion around transforming the mental health system to be recovery-oriented.

In conjunction with the Provincial Recovery Working Days, the Mental Health Commission of Canada released their national *Guidelines for Recovery-Oriented Practice*. The national guidelines outline the principles, values, knowledge, skills and behaviours that underlie recovery-oriented services and supports, as well as the capabilities and leadership required to successfully implement them. The national guidelines support system change at a practice level and complements this report which is intended to provide guidance for change at a systems level.

WHAT IS RECOVERY AND RECOVERY-ORIENTED MENTAL HEALTH SERVICES?

The Provincial Recovery Champions Committee has established provincial definitions for recovery and recovery-oriented mental health services to build common language around recovery across Manitoba. They are as follows:

Recovery

Recovery is a journey of healing and growth that is owned by and unique to each individual.

- Recovery builds on individual, family, spiritual, cultural and community strengths and enables a person to live a resilient, meaningful, and satisfying life of their choice in the community, in the presence or absence of symptoms of mental health problems and illnesses.
- Recovery is nurtured by relationships with self and others, and by environments that provide hope, empowerment, acceptance, choices, and opportunities.
- Family members, service providers, peers, and others may be partners in one's journey of recovery.

Mental Health Recovery-Oriented Services and Practice

While recovery is owned by and unique to each individual, mental health services have an important role in creating an environment that supports, and does not interfere with, people's recovery efforts.

- Supporting personal recovery is the first and main goal of recovery-oriented mental health services. Providing treatment can be an important contribution towards this goal, but is a means not an end. Similarly, intervening in crisis or addressing risk issues may sometimes need to take precedence, but should be oriented around the primary goal of supporting recovery.
- Service providers, including peer support workers, work in a manner that supports wellness and focuses on strengths.
- Recovery-oriented practice emphasizes hope, social inclusion, acceptance, choice, community participation, personal goal setting, and self-management.
- Recovery-oriented practice involves a holistic approach that addresses a range of factors that impact on people's well-being, such as housing, education and employment, and family and social relationships.
- In recovery-oriented service and practice, service providers consider how responsibility, information, and power are shared and discuss this as they engage with those who access mental health services.

Additional definitions for key terms such as peer support, etc. can be found in Appendix C.

USING THE REPORT AND TOOL TO CREATE SYSTEM CHANGE

One of the key outcomes from the Provincial Recovery Working Days was the consensus of what a recovery-oriented mental health system should look like in Manitoba. As well, participants identified priority areas they felt should be the initial focus for system transformation efforts in Manitoba; and brainstormed system level indicators for each of these priority areas. This was accomplished through a number of small group activities and validation exercises that took place over the course of the working days. This work has informed the content within this report.

Hope Changes Everything: A guide to recovery-oriented system transformation in Manitoba is meant to guide change at a systems level (regional and provincial). The overall goal is to create a shift in the way that services are delivered to people with lived experience of mental health problems and illnesses.

This report and accompanying tool is meant to be used by regional partners to collectively measure and guide their efforts to provide services in more recovery-oriented ways across the service system. The priorities for transformation identified within the report will inform the development of consistent recovery-oriented services. Individual organizations such as regional health authorities and mental health self-help agencies are also encouraged to utilize the report and tool to self-evaluate their existing recovery work and identify areas that can be improved. It is strongly encouraged that individual organizations who do embark on single organization initiatives that they work in partnership with the regional partners to keep them informed of activities taking place.

Here is a step by step guide for regional recovery committees or organizations on how to utilize the report and tool.

Step #1: Create a regional recovery committee

Creating effective recovery-oriented services and systems is based on developing strong partnerships and engaging all stakeholders, especially people with lived experience of mental health problems and illnesses; and their family members or natural supports. Under the leadership of the regional health authority, the first step is to establish a regional recovery committee that is continuously striving towards achieving a membership composition that has a minimum of 50 per cent of its membership made up of PWLE; and family members. The remainder of the membership should include broad representation from the Regional Health Authorities' various mental health services and funded agencies; mental health self-help agencies; and other key stakeholders within the geographic region.

Step #2: Conduct a self-assessment and rank local transformation priorities

Once the regional recovery committee is formed, the committee should carefully review and discuss each of the 10 transformation priorities within this report. Together the regional recovery committee will determine through self-assessment which stage (ex: stage 1 - engagement, stage 2 – development, or stage 3 - transformation) their respective region (or organization) has achieved for each transformation priority. Definitions of the three stages can be found below. At the end of this report, you will find a tool in appendix A that will help guide you through the self-assessment process and document your findings.

The regional recovery committee should come to a consensus on which transformation priorities (2 to 3) will be the focus of initial work. Over time, the expectation is that the regional recovery committee will work on each of the 10 transformation priorities in order to achieve the system transformation that has been identified for Manitoba.

Through completing the self-assessment process for each transformation priority, the regional recovery committee will develop a summary of the current status of recovery-orientation in their region (or organization), and benchmarks to assist with planning and evaluation. Regional recovery committees are encouraged to visit the provincial recovery webpage at **www.gov.mb.ca/healthyliving/mh/recovery** frequently to access more examples of indicators and resources related to each of the transformation priorities listed in this report.

Step #3: Develop a work plan

Utilizing the tool at the end of the report (appendix B), the regional recovery committee will work together to develop an annual work plan to guide the work of the

committee. Within the work plan, the committee will document their agreed upon goals, specific indicators to measure progress being made (suggestions are provided for each transformation priority and more can be found on the Mental Health and Spiritual Health Care Branch's recovery webpage www.gov.mb.ca/healthyliving/mh/recovery.html) and an implementation plan with timelines. The regional recovery committee should regularly monitor progress being made and update the work plan as required. Committees will be required to share their work plans and progress made with the Mental Health and Spiritual Health Care Branch of Manitoba Health, Healthy Living and Seniors. The Branch will also establish knowledge sharing mechanisms so regions can share their work and learn from others.

Step #4: Evaluate progress and update work plan

As per the work plan, regional recovery committees will have a clear plan for how they will evaluate progress made utilizing agreed upon indicators (ex: annual review of data, etc.). The regional recovery committee will update its work plan annually and determine if additional transformation priorities can be taken on based on a review of the measurement data.
For each additional transformation priority taken on, the committee will follow the steps outlined above.

Definitions of the Three Stages

Stage 1 – Engagement

The system/organization is engaged and intends to deliver recovery-oriented services. At a Board/senior leadership level, evidence can be seen that there is understanding and acknowledgment that the system/organization needs to transform towards delivering more recovery-oriented services for people with lived experience of mental health problems and illnesses; and families. There is awareness within the system/organization that there are existing areas within the system/organization that are delivering recovery-oriented services and there is commitment to build on what is already working well. A work plan to deliver recovery-oriented services has been developed but little progress has yet been made with implementation.

Stage 2 – Development

There is some evidence that actions are being taken, with significant changes in practice, policy and culture that are aligned with recovery principles. Recovery-oriented services are being delivered in many areas across or within the system/organization, but not consistently throughout the whole system/organization.

Stage 3 – Transformation

The vision of having recovery-oriented services has been achieved. Recovery-oriented policies, processes and practices are embedded in every level of the system/organization. Quality improvement processes have been developed and are in place to ensure ongoing review and improvements are continuously made.
The system/organization participates and partners with key stakeholders in the delivery of initiatives/projects that focus on promoting positive mental health and well-being for people of all ages.

Adapted from *Implementing Recovery – A Methodology for Organizational Change* by Geoff Shepherd, Jed Boardman and Maurice Burns.

TRANSFORMATION PRIORITY #1:
Providers will seek flexible ways to change the experience and day to day interactions with individuals.

Stage 1: Engagement

There is recognition within the system/organization that recovery principles and values are important, but few systematic attempts have been made to implement them by changing staff behaviour. Staff, physicians, PWLE and their families are familiar with the general principles, but unclear about their implications for practice. PWLE are not generally consulted regarding the quality of services delivered and staff performance.

Stage 2: Development

There is clear evidence within the system/organization of a recognition that every significant encounter by every member of staff and physicians should reflect recovery principles and promote recovery values—aimed to increase self-control (agency), increase opportunities for life 'beyond illness', and validate hope. Wherever possible, staff and physicians utilize coaching methods. Some attempts have been made to ensure that these principles are reflected in practice but these are not reflected in routine staff supervision. There is evidence of some involvement of PWLE in staff selection, but this is not routine.

Stage 3: Transformation

Every significant encounter by every member of staff and physicians aims to reflect recovery principles and promotes recovery values—increasing self-control (agency), increasing opportunities for life 'beyond illness', and validating hope. Each interaction acknowledges non-professional expertise and attempts to minimize power differentials. There have been systematic attempts to ensure that these principles are reflected in day-to-day practice. Staff and physicians across the system/organization report utilizing coaching methods wherever possible. The importance of the quality of staff/PWLE interactions has been incorporated into staff supervision and performance ratings. PWLE are routinely involved in staff selection. Human resource policies validate recovery training and link this to opportunities for staff progression.

Example of indicators:

- proportion of staff and physicians trained in basic recovery-oriented practices
- systematic surveys of PWLE and family perceptions of staff behaviour in relation to recovery principles
- supervision and appraisal systems are revised to promote staff interactions that demonstrate working in partnership with PWLE and families
- percentage of staff by program area that report successfully including a wide variety of approaches for their participants
- percentage of participants by program area that report feeling encouraged to experiment with a variety of approaches

TRANSFORMATION PRIORITY #2:
Recovery-oriented practice and service delivery promotes a hopeful approach to mental health problems and mental illness; and challenges stigma and discrimination, first within mental health services.

Stage 1: Engagement

There is understanding throughout the system/organization that stigma and discrimination against PWLE exists at all levels within the system/organization and is being internalized among PWLE. The negative impact of stigma and discrimination faced by PWLE can be seen in many areas such as accessing mental health services, active participation in treatment decisions, determining tolerance for risk, employment, relationships, securing housing and exercising civic roles and rights. The system/organization is working towards developing and implementing initiatives within its own system/organization to reduce institutionalized discrimination and ensure that the system/organization is a safe place for people to talk about their experiences with stigma and that action is taken when stigmatizing and discriminatory policies, processes or practices are identified. The system/organization is taking a proactive approach by engaging PWLE and families in the review of policies, processes and practices to ensure they are

not discriminatory or stigmatizing, and don't impact access to programs and services, but little progress has been made yet.

Stage 2: Development

The system/organization is contributing to the reduction of stigma and discrimination by delivering and incorporating messages of hope and social inclusion into all aspects of the system/organization. Policies, processes and practices have been reviewed to ensure they are non-stigmatizing and discriminatory. Action has been taken when stigmatizing and discriminatory policies, processes or practices have been identified. Education on using non-stigmatizing language, verbally and in documentation, has been widely delivered throughout the system/organization. Staff and physicians feel empowered to use non-stigmatizing language on their work. There is ongoing dialogue in safe environments for people to talk about their experiences of stigma and discrimination, including within the mental health system/organization. Services are focusing on people's strengths and capabilities. Wherever possible, the experience of mental distress is normalized throughout the system/organization and people are supported to find purpose and meaning in their lives. While there are many improvements throughout the system/organization, there are still some areas that are discriminatory or stigmatizing towards PWLE.

Stage 3: Transformation

A culture of hope is embedded, modeled and communicated by staff at every level throughout the system/organization. The staff and physicians within the system/organization are knowledgeable on best practices and research in stigma reduction and of ways to address discrimination. There is evidence of the best practices being incorporated into the delivery of programs and services. Anti-stigma audits have been developed based on best practice and are conducted regularly to identify areas that can be further improved. There is open discussion for staff, physicians and PWLE to discuss stigmatizing behaviours. The system/organization participates in local initiatives that promote positive understanding of mental health problems and illnesses; and reduces stigma and discrimination.

Examples of indicators:

- number of anti-stigma audits (co-designed by PWLE and families), completed and the number of changes made as a result of the results
- number of system/organizational policies and procedures reviewed and revised, in collaboration with PWLE and families, to eliminate institutional discrimination
- number of system/organizational policies and procedures reviewed and revised, in collaboration with PWLE and families, to eliminate stigmatizing language
- percentage of people with lived experience of mental health problems and illnesses and families that report the organization has a culture of hope
- percentage of internal and external materials (educational, orientation, etc.) that have been reviewed and revised, in collaboration with PWLE and families, in order to communicate principles of recovery and ensure language is positive, encouraging of inclusion and hopeful

TRANSFORMATION PRIORITY #3: There is clear system/organizational leadership supporting and championing change in culture to ensure that all aspects of practice communicate recovery-oriented principles.

Stage 1: Engagement

The system/organization's mission and vision clearly demonstrate a strong commitment to delivering recovery-oriented services. There is understanding and desire to move the culture of the system/organization from a "problem-based approach" to a "strengths-based" approach. At a board of director's level there is a strong understanding of the importance of delivering recovery-oriented mental health services. A work plan has been developed to review policies and practices to ensure they communicate recovery-oriented principles but little progress has been made with implementation. Within the system/organization, there are recovery champions who are implementing recovery-oriented principles into all aspects of their teams work but they are working in isolation.

Stage 2: Development

The system/organization has identified priorities within its work plan and has begun implementation. The system/organization has developed organizational policies at all levels that align with provincial policy and reflect all the core principles and values of recovery found within the policy. There is evidence that the culture has changed to a recovery-oriented strengths-based approach in all levels of the system/organization (ex: internal and external communication of the system/organization, training workshops, etc.). PWLE and family members are clearly valued members and are contributing at all levels within the system/organization. The system/organization has developed and implemented validated tools to routinely audit the experience and satisfaction of PWLE and families. A process is also in place to follow through on feedback received from the audit process. Some internal "pathways" (ex: referral systems, assessments, discharge planning, etc.) have been reorganized, with input from PWLE and families, to ensure they support recovery processes. Whilst there are a number of recovery initiatives, it is recognized that cultural change has not yet occurred at all levels and in all parts of the system/organization. Monitoring recovery-oriented practice may not appear in staff supervision.

Stage 3: Transformation

Recovery concepts and values are evident and embedded at all levels of the system/organization (ex: policies, management processes, employee recruitment, supervision and appraisals, etc.). There is strong leadership and action at the board level to ensure that this is reflected through all levels of management and by staff and physicians. Throughout the system/organization recovery-oriented services promote an environment of hope, optimism, and inclusion that recognizes uniqueness and strengths, where people feel valued, important, welcome and safe.

Examples of indicators:

- percentage of system/organizational policies and procedures that demonstrate a commitment to recovery and are aligned with provincial policy
- number of internal "pathways" that have been reviewed and redesigned with PWLE and families in order to better support recovery processes and outcomes
- percentage of PWLE who report positive experiences with the system/organization (or with the program/service) that supported their personal recovery journey
- number and description of changes that have been made to service delivery based on input from PWLE and families
- percentage of staff and physicians from a program area that routinely use individual recovery outcome measures

TRANSFORMATION PRIORITY #4: Increasing opportunities for building a life "beyond illness."

Stage 1: Engagement

The system/organization is committed to facilitating opportunities for PWLE to participate in their community of choice and to engage their rights and responsibilities of citizenship. System/organizational policies and practices reflect that PWLE will be supported by staff and physicians to identify how they define community involvement, leisure activities and citizen participation; and will be supported to achieve these goals as part of their recovery plan. There is evidence within the system/organization in the practice of staff and physicians that this is part of the recovery plan but it is not being consistently applied. Some effective partnerships do exist with other sectors such as housing, employment, and education but this is inconsistent.

Stage 2: Development

The system/organization has in place a strategy for the development of "mainstream" community support (including housing, employment, leisure and mental health promotion) and good progress has been made regarding implementation but there is still some inconsistency. The system/organization has effective

partnerships in place to provide improved access to paid employment. Operational policies have been revised to promote community integration on discharge from inpatient care. PWLE report that they feel that they have received the support they needed to develop a plan that is safe and will sustain their recovery.

Stage 3: Transformation

The system/organization recognizes that full citizenship and community integration is essential in promoting individual recovery. It has developed a range of effective partnerships with external organizations to support individuals in building a life for themselves independent of formal mental health services. In practice, there is a focus on promoting settled accommodation; maintaining and developing relationships; paid employment and training, or volunteer work if the person with lived experience prefers; and full inclusion in ordinary community activities. Peer support networks have been developed to sustain community inclusion. There is a particular emphasis on the importance of paid employment if the PWLE has identified this as a goal. The system/organization supports social inclusion through a comprehensive range of targeted anti-stigma work, led by PWLE in the communities that it serves.

Examples of indicators:

- rates of PWLE participating in paid employment by program area
- number of recovery plans by program area that demonstrate an adequate assessment of the person's goals (ex: employment/volunteer/ community integration) and appropriate action plans
- percentage of PWLE that report having a life beyond illness (ex: relationships, employment, volunteer work, etc.)
- audit the effectiveness of discharge plans in sustaining recovery
- percentage of PWLE in a program area that report their goals and visions are discussed with service providers and physicians

TRANSFORMATION PRIORITY #5: Peer support is valued, recognized and embedded into the system/organization.

Stage 1: Engagement

The system/organization recognizes the importance of peer support and understands how peer support workers can inspire hope and demonstrate the possibility of recovery. Peer support workers are valued throughout the system/organization for their authenticity because they can relate to the challenge of mental health problems and illnesses and have found their way to recovery. The system/organization recognizes the need to respect the core values of peer support and its authenticity. PWLE have received information on the benefits of peer support. The system/organization is committed at all levels to build on the availability and accessibility of peer support, one-to-one relationships and group peer support that currently exists within the system/organization but little progress has been made in developing and implementing a concrete plan.

Stage 2: Development

The system/organization has developed and begun implementing a comprehensive work plan in partnership with PWLE and self-help agencies to enhance access to peer support within all programs and services. There is evidence within the system/organization that peer support is valued and an important component of a person's recovery plan. Education on peer support has been delivered at all levels within the system/organization including to PWLE and family members. Peer support workers are regarded at all levels within the system/ organization as valuable members of the team and their role in delivering peer support is respected. The peer support workers have clear job descriptions that support the core values of peer support and allow flexibility for the peer support workers to accomplish their unique role. A supervision and management framework has been established and is being followed. Even with all these changes, there is still some inconsistency within the system/organization.

Stage 3: Transformation

Peer support is available and offered to PWLE in programs and services within the system/organization. PWLE who want a peer support worker report having access to a peer support worker when requested and that careful consideration is made with the match to ensure it aligns with people's experiences and experienced distress, not necessarily diagnosis. Family members report having access to family peer support workers when requested. The system/organization supports the process that is involved in making an ideal match and fosters the match by ensuring the PWLE/family member and the peer support worker have opportunities to build their relationship. All teams within the system/organization are diverse with peer support workers and professionals from multiple disciplines. Peer support workers report feeling valued, recognized and important members of the system/organization. A quality improvement process has been developed to evaluate existing programs and services; and to identify ways to improve the incorporation of peer support throughout the system/organization.
The system/organization participates and promotes the value of lived experience and peer support within the broader community whenever possible.

Examples of indicators:

- number of peer support workers who are delivering one-on-one support to people with lived experience within a program area
- percentage of requests for a peer support worker filled within a program area.
- number of partnerships established to increase access to peer support within the system/organization
- percentage of PWLE and family who report having timely access to peer support workers
- percentage of organizational policies and procedures that demonstrate the value and embedding of peer support within all programs and services

TRANSFORMATION PRIORITY #6:
People with lived experience of mental health problems or illnesses and family members are contributors in improving services and their input is seen as critical for the design, delivery and review of services.

Stage 1: Engagement

At all levels within the system/organization there is understanding of the value of lived experience and desire to ensure PWLE and family members with diverse perspectives and backgrounds have meaningful input in the design, delivery and evaluation of all programs and services. There are some examples within the system/organization where PWLE and family members are providing input into the design, delivery and evaluation of a program or service but it is not ongoing or consistent. The system/organization would like to build on these examples and ensure that all programs and services are utilizing a consistent inclusive approach but little progress has been made in moving this forward.

Stage 2: Development

A work plan has been developed to create different opportunities within the system/organization for PWLE and family members with diverse perspectives and backgrounds to provide meaningful input into the design, delivery and organization of services (ex: advisory committee, surveys, focus groups, working groups, consultations). Staff and physicians at all levels within the system/organization have received training on how to create an inclusive environment for PWLE and family members where they feel supported to provide input. PWLE and family members who are providing input feel valued and supported in this role. There is some evidence within the system/organization that the feedback given by PWLE and family members has influenced changes to the design, delivery and evaluation of services. The system/organization has adopted a policy that reflects these changes but there are still some inconsistencies within the system/organization.

Stage 3: Transformation

The knowledge and expertise of PWLE is incorporated into planning, implementing, evaluating and improving services on a consistent basis. A quality improvement process, with participation from PWLE and family, is in place to ensure ongoing review and improvements are made. The system/organization participates and promotes the value of lived experience and peer support within the broader community whenever possible. The system/organization shares knowledge gained through feedback from PWLE with other community groups in order to improve system delivery across their region and provincially.

Examples of indicators:

- establishment of an advisory committee of PWLE and families that will provide advice to the system/organization
- committees within the system/organization that are related to design, delivery and evaluation of services will strive to have at least 50 per cent of its membership made up of PWLE and family members
- percentage of PWLE and family who report feeling valued as members of the system/organization having an equal voice in the design, delivery and evaluation of services
- number of policies and documents reviewed by PWLE
- number of pathways for PWLE to provide input (ex: surveys, focus groups)

TRANSFORMATION PRIORITY #7:
The unique role of personal and family relationships in promoting well-being, providing care and fostering recovery across the lifespan is recognized, valued and supported.

Stage 1: Engagement

There is recognition that the role of family and natural supports is a valuable one in supporting recovery, promoting wellness, and delivering care, but there is no consistent process in place to encourage and support involvement. The PWLE has the right to define their "circle of support" and family involvement, with consideration for what is age appropriate. The system/organization recognizes that family and natural supports have their own needs and require support in order to be successful in a caregiving relationship. Some staff and physicians report involving family with the development of recovery plans and completing individual assessments of primary caregivers, but it is on an ad hoc basis and there is no policy or practice guideline to ensure it.

Stage 2: Development

There is a growing move to include family and natural supports in recovery plans and completing individual assessment of primary caregivers to determine needs, but there is no policy that governs it. Or there is a policy but it is not clear whether it is implemented consistently. People who use services report that staff and physicians encourage and support family involvement, and articulate its importance. Family and natural supports report that they have received some support to help them in their caregiving role but they are still finding the role stressful. A policy and procedure guideline for family involvement and support is in development utilizing the Family Caregiver Guidelines developed by the Mental Health Commission of Canada as a best practice.

Stage 3: Transformation

Recognizing, valuing and supporting the role of personal and family relationships is a key principle of the system/organization. There are strong policies and practice guidelines which reflect the principles. All participants/clients are encouraged to involve their families and natural supports, in meetings, recovery plans, and organizational planning and governance, within the context of individual choice and personal health information legislation. Discussions around not involving family are re-visited with individuals at reasonable intervals. Where family involvement is not an option, efforts are still made to consider caregiver and other family member needs, and to offer information and referral, as appropriate.

Example of indicators:

- number of recovery care plan meetings in a program area that have included family and natural supports (with permission from the PWLE)
- number of assessments completed in a program area with the primary caregiver to determine level of burnout
- number of system/organizational policies developed/adapted to encourage and support family and natural support inclusion
- percentage of family members who have reported feeling valued and a part of the recovery planning process
- number of skill building sessions for family and natural supports

TRANSFORMATION PRIORITY #8: People with lived experience of mental health problems and illnesses are empowered with choice and are supported in their decision making utilizing appropriate risk assessment and management tools.

Stage 1: Engagement

The system/organization recognizes that PWLE have the right to exercise self-determination, to exercise personal control, to make decisions and to learn and grow though experience. The system/organization would like to develop practices and procedures that support open, transparent risk assessment and management policies but little progress has been made. Some staff and physicians understand how to complete risk assessments, implement risk reduction methods and utilize trauma informed care in their practice but this is not consistent across the system/organization and not all staff and physicians are consistently applying these approaches.

Stage 2: Development

There is recognition at all levels within the system/organization of the need for safety while actively promoting "positive" risk taking. The system/organization has developed and introduced policies and procedures that support open, transparent risk assessment and management policies but these have not been implemented throughout the whole system/organization. Training has been delivered to staff and physicians on this area and best practices are being shared throughout the system/organization but not all staff and physicians are involving PWLE in their own risk assessment process. The system/organization has also delivered training to build cultural competency within the system/organization but not all staff and physicians have received clinical supervision on how to implement their new education into practice. PWLE report receiving support to develop risk assessments and safety plans but this is not consistent across all program areas. Family members report receiving education on risk assessment, management and the role of family in supporting the autonomy of the PWLE but this is not consistent across all program areas and families are still concerned about their role. Staff and physicians report that they do not feel full support to put the policies and procedures into practice.

Stage 3: Transformation

The system/organization has in place systems and procedures that support staff and physicians in open, transparent risk assessment and management practices that align with recovery principles, trauma informed care and cultural competencies. The majority of PWLE routinely report being a part of the risk assessment process and developing effective safety plans. Staff and physicians are trained and comfortable utilizing this approach in their practice. Family members report greater understanding of risk assessment, management, how they can support their loved one and how to access services when needed. The culture within the system/organization and staff attitudes and values are aligned with the new direction of the system/organization. There are mechanisms within the system/organization for staff and physicians to have open dialogue on "positive" risk, safety and sharing of experiences. The system/organization has successfully reconciled the need to balance its duty of care to provide safe services while promoting a positive approach to risk assessment and management.

Examples of indicators:

- percentage of staff and physicians in a program area that have received training in risk assessment and harm reduction
- percentage of family members who have received education and training on risk assessment and harm reduction
- percentage of PWLE that report feeling empowered to be a part of the risk assessment process and have developed an effective safety plan
- number of mechanisms in place to review incident reports and draw learnings from these experiences so they can be shared
- risk management policies reflect a shift towards supporting positive risk-taking, while ensuring appropriate corporate governance and adherence to safe practice and regulatory requirements

TRANSFORMATION PRIORITY #9: A range of recovery-oriented, evidence-informed practices, services and supports are available in the community to increase personalization and choice.

Stage 1: Engagement

The system/organization recognizes and is committed to ensuring that recovery planning is focused on the whole person and is responsive to people at different stages of life, from diverse backgrounds and sexual orientation, with different abilities, of all religious beliefs and spiritual practices, language groups and communities. In addition, recovery planning will support the goals and priorities of PWLE but this new approach has not been widely implemented or monitored.

Stage 2: Development

There is a growing movement towards greater personalisation and choice in terms of treatment and management options. The system/organization has developed a comprehensive work plan that includes training for staff and physicians at all levels in the use of tools such as the Wellness Recovery Action Plan (WRAP) in the development of recovery plans; implementation of advance care planning across the organization; the development of a range of information and education on self-management approaches; and policy development that reflects shared decision making and joint planning. PWLE report receiving the support they need to develop their own recovery plans and to achieve their personal goals. The system/organization has formed partnerships with organizations within the community in order to deliver more responsive services and to ensure appropriate referrals are made when needed. There is evidence that services have been adapted and are responsive to people's needs but there is still some inconsistency throughout the system/organization.

Stage 3: Transformation

At all levels within the system/organization there is evidence through staff and physician practice that there is an emphasis on life goals and PWLE are supported to develop their own recovery plan, at a level they are comfortable with. The planning and delivery of all services are designed to address the unique circumstances, history, needs, expressed preferences and capabilities of each PWLE toward a journey of recovery. There is continuous evaluation to measure system/organizational commitment to personalisation and choice. The system/organization has partnered with other stakeholders in initiatives that promote a continuum of recovery oriented opportunities and positive mental health and well-being of people at different stages of live, from diverse backgrounds and sexual orientations, with different abilities, of all religious beliefs and spiritual practices, language groups and communities.

Examples of indicators:

- number of program areas that are utilizing Wellness Recovery Action Plans (WRAP) or similar recovery plans in their practice
- percentage of PWLE that report feeling actively involved in planning and determining the content of their recovery plan
- number of advance care directives in place in a program area

- number of policies and procedures that are inclusive to the needs of people at different stages of life, from diverse backgrounds and sexual orientations, with different abilities, of all religious beliefs and spiritual practices, language groups and communities
- percentage of PWLE that report a welcoming and responsive experience when accessing services and programs from the system/organization

TRANSFORMATION PRIORITY #10: The workforce will be knowledgeable, competent, skilled, diverse and committed to supporting recovery first and foremost.

Stage 1: Engagement

The system/organization is committed and prioritizes a workforce that delivers recovery-oriented services at all levels of the organization. There is recognition that transforming the workforce may require a change in the skill mix and balance between traditional mental health professionals and people whose expertise comes from lived experience. There are plans underway to provide additional training to staff and physicians in order to deliver recovery-oriented services and to adapt workplace practices so they support recovery-oriented service delivery but little progress has been made yet.

Stage 2: Development

There is evidence throughout the system/organization that the workforce is committed to supporting recovery and is continuously improving practices based on the latest research and feedback from PWLE. Interdisciplinary teams that incorporate the skills of all professional disciplines, including alternative approaches can be found throughout the organization but not within all areas. The environment within the system/organization supports individuals who wish to disclose their lived experience. The system/organization is actively recruiting PWLE at all levels within the system/organization, including at senior management levels. The system/organization has adopted a physiological and health safety policy in the workplace and begun implementing a number of initiatives to create a healthy workplace for all employees.

Stage 3: Transformation

The system/organization's culture encourages staff and physicians to use their own experiential knowledge, where appropriate, to inspire hope and model recovery. The system/organization's professional development across the workforce and continuous improvement processes include ongoing learning and skill development and encourage reflection of how to strengthen recovery-based practice. The system/organization strives to have mentally healthy and psychologically safe workplaces.

Examples of indicators:

- number of yearly training opportunities for staff and physicians on recovery principles, values and practices led by PWLE
- number of yearly opportunities for staff and physicians to discuss and problem solve around the implementation of the recovery model, in collaboration with PWLE
- number of recruitment procedures that promote the selection of staff with the appropriate values, attitudes and knowledge, drawn both from lived experience and academic or professional education, to support recovery processes
- percentage of staff and physicians who voluntarily disclose they have lived experience
- percentage of staff and physicians by program area that report changes in their individual approach to practice in order to support the organization's vision and service delivery goals

APPENDIX A: SELF-ASSESSMENT TOOL

TRANSFORMATION PRIORITY:	STAGE 1	STAGE 2	STAGE 3	WHAT HAS THE SYSTEM/ ORGANIZATION ACHIEVED?	WHAT ARE THE NEXT STEPS?	OTHER COMMENTS/ OBSERVATIONS:
	Select one based on self-assessment					
1) Providers will seek flexible ways to change the experience and day to day interactions with individuals.						
2) Recovery-oriented practice and service delivery promotes a hopeful approach to mental health problems and mental illness; and challenges stigma and discrimination, first within mental health services.						
3) There is clear system/ organizational leadership supporting and championing change in culture to ensure that all aspects of practice communicate recovery-oriented principles.						
4) Increasing opportunities for building a life "beyond illness."						

TRANSFORMATION PRIORITY:	STAGE 1	STAGE 2	STAGE 3	WHAT HAS THE SYSTEM/ ORGANIZATION ACHIEVED?	WHAT ARE THE NEXT STEPS?	OTHER COMMENTS/ OBSERVATIONS:
5) Peer support is valued, recognized and embedded into the system/organization.						
6) People with lived experience of mental health problems or illnesses and family members are contributors in improving services and their input is seen as critical for the design, delivery and review of services.						
7) The unique role of personal and family relationships in promoting well-being, providing care and fostering recovery across the lifespan is recognized, valued and supported.						

TRANSFORMATION PRIORITY:	STAGE 1	STAGE 2	STAGE 3	WHAT HAS THE SYSTEM/ ORGANIZATION ACHIEVED?	WHAT ARE THE NEXT STEPS?	OTHER COMMENTS/ OBSERVATIONS:
8) People with lived experience of mental health problems and illnesses are empowered with choice and are supported in their decision making utilizing appropriate risk assessment and management tools.						
9) A range of recovery-oriented, evidence-informed practices, services and supports are available in the community to increase personalization and choice.						
10) The workforce will be knowledgeable, competent, skilled, diverse and committed to supporting recovery first and foremost.						

APPENDIX B: WORK PLAN TEMPLATE

Transformation Priority # *(insert description of transformation priority)*					
Self – Assessment Results: *Stage 1 ( ) Stage 2 ( ) Stage 3 ( )*					
No.	**Goals**	**Tasks**	**Who is responsible?**	**Indicator(s) to monitor progress**	**Timeline/ Deadline**
1					
2					
3					
4					
5					

APPENDIX C: KEY DEFINITIONS

People with lived experience of mental health problems and illness (PWLE): When we use this phrase in the document, we are referring to individuals who have experience with "clinically significant patterns of behaviour or emotions that are associated with some level of distress, suffering, or impairment in one or more areas such as school, work, social and family interactions, or the ability to live independently" (Toward Recovery & Well-Being: A Framework for a Mental Health Strategy for Canada, Mental Health Commission of Canada, 2009).

Family: When we use the phrase family in the document, we are referring to an individual's family members or natural supports.

Peer Support Worker: Peer support is a supportive relationship between people who have a lived experience in common. The experience that individuals or groups have in common is in relation to a mental health chal¬lenge or illness. This common experience might be related to their own mental health or that of a loved one. In the case of this report, Peer Support Workers are not service providers who happen to also have lived experience of mental health problems and illnesses. They are stand alone positions within the system/organization for which lived experience is a role requirement.

Wellness Recovery Action Plan (WRAP): The Wellness Recovery Action Plan® or WRAP®, is a self-designed prevention and wellness process that anyone can use to get well, stay well and make their life the way they want it to be

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The concept of the Hope Changes Everything: A Guide to Recovery-Oriented System Transformation in Manitoba is based on the UK's Sainsbury Centre for Mental Health's policy document: "Implementing Recovery: A Methodology for Organisational Change" written by Geoff Shepherd, Jed Boardman; and Maurice Burns.

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