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INSIDE

SPECIAL ISSUE:

Recovery-oriented psychosocial rehabilitation practice

Guest Editors: Regina Casey, PhD, OT, and Skye Barbic, PhD, OT

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Editorial: Occupational therapists as key collaborators in psychosocial rehabilitation, recovery orientation and Canadian mental health reform

Skye Barbic and Regina Casey

In the last half-century, mental health services in Canada have changed dramatically (Kidd, McKenzie, & Virdee, 2014). Not only has care shifted from institutionalized settings to the community, but the evidence-based approach to assessment, treatment planning and evaluation has evolved to emphasize a person-centered approach and the promotion of citizenship as best practice (Kidd et al., 2014). Today, the aim of treatment is to work side by side with people with mental illness and their loved ones, with a shared sense that recovery is possible. For the purposes of this issue of *Occupational Therapy Now (OT Now)*, we use William Anthony's (1993) definition of recovery, which is a "way of living a satisfying, hopeful, and contributing life even with limitations caused by illness" (p. 15).

We are learning that practicing recovery in our respective places of work, and doing it well, remains an enormous challenge. For example, barriers such as social stigmatization, injustice and complex institutional policies and procedures pose challenges to the implementation and underlying philosophy of recovery (Drake & Whitley, 2014). With growing stakeholder interest in mental health and health equity, and data indicating that one in five Canadians is directly affected by mental illness each year (Statistics Canada, 2011), a careful plan to respond to the mental health needs of Canadians is needed.

In 2006, Canada's foundational report asserting the need for mental health system reform anchored in a recovery orientation was published (Standing Senate Committee on Social Affairs, Science and Technology, 2006). This publication led the way to the development of the *Mental Health Strategy for Canada* (Mental Health Commission of Canada [MHCC], 2012) and the *Guidelines for Recovery-Oriented Practice* (MHCC, 2015). These publications are complementary to work by Psychosocial Rehabilitation/Réadaptation Psychosociale (PSR/RPS) Canada, who identify principles and values (PSR/RPS Canada, 2014, code of ethics (PSR/RPS Canada, 2016) and competencies for Canadian recovery-oriented practitioners (PSR/RPS Canada, 2013). Notably, as of June 2016, it is possible to apply to become a Canadian registered recovery-oriented PSR practitioner (see http://www.psrrpscanada.ca/).

The terms "recovery" and "PSR" are commonly used across many health settings to describe conceptual frameworks, principles of service orientation and targeted outcomes for care (Bird et al., 2014; Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). Psychosocial rehabilitation is based on 13 core principles and defined by Farkas (2013) as the skills, attitudes and behaviours, including evidence-informed practices, used by practitioners to promote and support the journey of recovery with and for people who live with mental illness so they may live successfully in communities of choice. This issue of *OT Now* provides evidence of the application of recovery and PSR principles in practice, and the role of occupational therapy in supporting the restructuring of our Canadian mental health system. The ideas presented in this issue have been selected to challenge the boundaries of our work and further the dialogue on recovery and PSR among members of our vibrant community. The articles are written by exemplary leaders who share the common goal of improving the mental health and well-being of all Canadians through meaningful occupation. The topics covered in the articles are examples of how occupation, or participation in meaningful activity, can support multiple personal meanings related to recovery, such as: (a) citizenship, recognition and skill development for social inclusion; (b) health, well-being and justice; and (c) those that resonate with developing the self or being "more fully human" (Casey, 2013, p. ii). We are confident that the articles not only reflect a current state of knowledge, but also a vision for the role of occupational therapists as collaborative, innovative leaders in health systems reform, evidence-based practice and the promotion of mental health for all.

With this issue of *OT Now*, we sought to present articles that reflect recovery-oriented practices from across our country. Further, we asked the authors to anchor the articles in the six dimensions of recovery-oriented practice, as identified by the MHCC's *Guidelines for Recovery-Oriented Practice* (title italicized) (2015). The dimensions include:

1. Creating a culture and language of hope
2. Recovery is personal
3. Recovery occurs in the context of one's life
4. Responding to the diverse needs of everyone living in Canada
5. Working with First Nations, Inuit and Métis
6. Recovery is about transforming services and systems

To complement your reading, we encourage you to immerse yourself in the *Guidelines for Recovery-Oriented Practice* (see: http://www.mentalhealthcommission.ca). They provide a shared vision, language and philosophy for recovery and PSR. Further, they serve as a foundation from which service providers can take risks and stretch the possibility of our thinking as evidence-based practitioners. We acknowledge that this issue captures only some

of the voices of our occupational therapy community. However, it is our hope that the readings offer an opportunity for all readers to reflect on their practice and the role for occupational therapy as a means to refining a person-centred, strengths-focused system of care that promotes the mental health of all.

For those readers who are new to occupational therapy, we hope the information inspires you to learn more about our profession and possibilities to partner with us. For those of you who have had the privilege of engaging in the mental health system's transformation over the last decades, we encourage you to reflect on how your skill set, values and actions can continue to contribute to the work and positively advance recovery-oriented policy, practice, education and research.

On June 20, 2016, Patricia Deegan, renowned scholar, leader and person with lived experience of mental illness, addressed the annual Canadian Psychosocial Rehabilitation Conference in Thunder Bay, Ontario. She sent a strong statement that our targets for care need to extend far beyond the numbers associated with psychiatric hospitalizations, treatment recidivism, emergency room visits and length of community tenure. She highlighted that currently many people with mental illness are deemed "success stories" if they stay out of hospital and minimize service utilization. By contrast, Deegan and other recovery leaders continue to push clinicians and other mental health stakeholders to consider contemporary outcomes associated with recovery. Such person-centred recovery outcomes may include employment tenure, engagement in family life, quality of life and citizenship. In order to capture these targets, we need to not only adopt recovery as a philosophy and ideal, but also as a measurable target for system reform.

Today, Canadian occupational therapists are presented with an ideal political, social and economic landscape to advocate for mental health service transformation. This issue of *OT Now* provides many examples of raising the bar for recovery-oriented care and considering the person, environment and meaningful occupation as means to the health and well-being of Canadians with mental illness. Many of the articles in this issue also highlight that strong leadership at all levels is critical if the vision of a transformed mental health system is to be realized. As well, key components of successful transformation are described. These include: partnering with experts who have lived experience and their loved ones, enhancing the coordination and accessibility of services across sectors and disciplines, and being accountable to measureable outcomes.

We acknowledge from the start of this issue that the global aim of PSR and recovery was never just an increase in community tenure or decrease in rates of psychiatric hospitalizations. Rather, the goal was and remains to expect that individuals live full and meaningful lives despite having a diagnosis of a mental health condition (Anthony, 1993). Join us in raising the profile of occupational therapy as part of an integrated model for mental health rehabilitation and promoting the mental health outcomes of all Canadians.

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What's new

Occupational Therapy Now call for papers

March 2017 – The Evolution of the Private Practice Occupational Therapist

Submission deadline: October 1, 2016. To view the full call for papers, go to: http://www.caot.ca/default.asp?ChangeID=25&pageID=7

For more information, contact: otnow@caot.ca

October is OT Month in Canada

Join CAOT in promoting our profession during occupational therapy month in October. CAOT's #31dayOTchallenge is back! With over 10 million impressions made on social media last year, we are encouraging fellow occupational therapists to participate in this year's 31-day challenge and, together, raise public awareness about occupational therapy!

Participation is simple. Starting on October 1st, talk to one person in your community each day about occupational therapy - in person, online, or by phone - and then share your interaction on Twitter or Facebook, using the hashtag (#) 31dayOTchallenge. Encourage your colleagues to help spread the word that occupational therapy works!

See www.caot.ca/OTmonth for more information regarding the challenge and for other OT month resources.

Welcome to CAOT-QC's managing director

We are pleased to introduce Ms. France Verville as the newly appointed managing director of the Canadian Association of Occupational Therapists–Quebec Chapter (CAOT-QC).

The managing director's role is to work toward ensuring a strong and united representational voice as advocate for occupational therapists living in Quebec. Ms. France Verville brings a wealth of knowledge and experience to this position, and together with the advisory committee will begin the development and work of the second provincial chapter of CAOT.

Join us in welcoming France to CAOT. You can reach her directly at: aceqc@caot.ca

Welcome to the CAOT Intern

CAOT is pleased to announce that Katelyn Bridge is the 2016/2017 CAOT Intern. The CAOT Intern position is offered to provide experience working at the National Office to an occupational therapist with recent postgraduate studies. Learning opportunities are provided to develop leadership capacity; promote the role of occupational therapists in public policy, advocacy and representation; and address current professional issues influencing occupational therapy through the development and/or application of research in practice.

2017 CAOT Conference news

Call for papers deadline extended

Feeling rushed to get your submission in for the CAOT Conference? With the conference being held June 21-24 in Charlottetown, PEI, we are extending the deadline for papers from October 1 to November 1. The online program and registration will also be available a month later, on March 1 instead of February 1.

CAOT Student Bursary for the 2017 Conference

All Canadian entry-level occupational therapy students will be eligible for this bursary if their university has five students whose abstracts have been submitted and accepted and who plan to present at conference. The winner of this bursary will be the student with the top-ranking abstract from each eligible university program. Winners will receive a share of this bursary up to a maximum of $500 (depending on donations collected) plus a complimentary registration.

New feature in *CJOT*: Introducing the State of the Art and the Science articles

As occupational therapy grapples with the challenges of implementing and sustaining innovative practice to better support occupational enablement, the *Canadian Journal of Occupational Therapy* (*CJOT*) is launching a new series of articles, entitled, "State of the Art and the Science." These articles will address current and emerging issues to help forge creative advances in practice. Each topic will synthesize evidence with imaginative, progressive thinking about ways to improve practice and maximize enablement of occupation. To learn more, read Jan Miller Polgar's editorial in the June 2016 issue of *CJOT*.

Updated CAOT Professional Development Calendar

Plan ahead and register early to take advantage of the professional development you need. Please visit www.caot.ca/education to consult an updated calendar with the CAOT professional development opportunities from October 2016 to September 2017.

WFOT news

The World Federation of Occupational Therapists (WFOT) recently launched the Occupational Therapy International Online Network (OTION), a free interactive forum that enables occupational therapists, assistants and students from across the world to network, share ideas and communicate with the profession as a whole (http://otion.wfot.org/).

Examining recovery-oriented practice from the perspective of the environment

Robin Mazumder

Health authorities across Canada are increasingly embracing recovery-oriented practice.

As the Canadian mental health-care system shifts toward a recovery service orientation and model of care, it would be beneficial for the profession of occupational therapy to delineate its unique contributions to the conversation on recovery. For occupational therapists, recovery-oriented care fits well within our approach to health care as well as our ethos as a profession. Given our holistic understanding of health and wellness, occupational therapists are positioned well to appreciate the complexity and intersectionality of experience recognized within the recovery model. We carry this outlook with us as we collaborate with clients in enabling their engagement in meaningful occupations (or daily activities) that play a role in their recovery journeys. Part of our holistic approach is derived from our acknowledgement of the impact of the environment on occupational engagement. The Person-Environment-Occupation (PEO) model identifies aspects of the environment that may impact engagement in meaningful activity: physical, social, economic, cultural and institutional (Law et al., 1996). Onken and colleagues (2007) posited that recovery can be viewed through an ecological framework in which the individual, the environment and the interplay between the two are analyzed. Embedded within the PEO model is the understanding that disability and related difficulties engaging in activity may be a product of barriers within the environment, rather than being located within the person (Law et al., 1996). This perspective gives occupational therapists much to offer.

In her 1991 Muriel Driver Memorial Lecture, Dr. Mary Law described how environments can constrain occupational engagement, citing power imbalances and a focus on normality as two sources of constraint. In that same lecture, Dr. Law called upon occupational therapists to improve their methods of understanding how it is that the environment can inhibit or enable occupation. This article intends to address ways in which physical environments can be influenced by recovery principles. The Mental Health Commission of Canada (MHCC; 2015) has identified six dimensions of recovery oriented practice:

1) Creating a culture and language of hope
2) Recovery is personal
3) Recovery occurs within the context of one's life
4) Responding to the diverse needs of everyone living in Canada
5) Working with First Nations, Inuit and Métis
6) Recovery is about transforming services and systems

If we take a deeper dive into these dimensions, we can see how an environmental lens on recovery could be of benefit.

There is an increasing surge of interest in the built environment and mental health. An interesting paper by Curtis, Gesler, Fabian, Francis and Priebe (2007) examined the design of in-patient mental health units; the authors discussed the notion of the therapeutic landscape, defining it as "a conceptual framework for analysing physical, social, and symbolic environments as they contribute to physical and mental health and wellbeing in places" (p. 592). There is an opportunity here for occupational therapists, as this idea aligns well with the PEO model. Curtis and colleagues explored hospital design and its relation to the empowerment of patients and the implications of design on security and surveillance. Importantly, they also discussed how the design of in-patient mental health settings should reflect the diversity of the patients that inhabit them. Occupational therapists work in such settings and have a comprehensive understanding of recovery principles. Perhaps influencing the design of mental health units so they support recovery principles is a tangible avenue for us to make a contribution.

If we take a step outside the walls of the hospital setting, we can also explore how it is that community design can stand to be influenced by recovery principles. A recurring theme in the MHCC *Guidelines for Recovery-Oriented Practice* (2015) is the importance of dignity. How can urban design practices support dignity? And how can occupational therapists take a leadership role in this issue? Mulholland, Johnson, Ladd and Klassen (2009) contended that urban design impacts the performance of occupations and called on occupational therapists to involve themselves in urban design. Occupational therapy prides itself with being a client-centred profession. Client-centredness resonates strongly with human-centred design, a design process that requires builders and designers to empathize with the people for whom they are designing. If we take a look at the current state of our cities, we can see

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Defensive architecture. Photo credit: Nils Norman. #dismlagarden http://www.dismalgarden.com/archives/defensive_architecture

that much of our built environment and infrastructure are not constructed with empathy in mind. We are aware of the link between poverty and mental health (Health Canada, 2002); taking this into consideration, what is the impact of how our cities are designed on those who are marginalized? In their paper titled "An Urban Geography of Dignity," Jacobson, Oliver and Koch (2009) described the plight of the poor urban pedestrian. They highlighted the indignity that pedestrians experience as they have to navigate environments that are inconvenient and difficult. While it may not be directly obvious to the engineers and policy makers who decide how our cities are built, our built environments have an impact on dignity. When I worked as an occupational therapist in an in-patient mental health unit at the Centre for Addiction and Mental Health in Toronto, I had an enlightening conversation with the peer support worker on the team. He brought forward the concept of "dignity encounters"—that as a health-care professional, I should be cognizant of how to promote experiences of dignity for the clients I supported. These dignity encounters were influenced by my body language, the language I used and the way in which I engaged with clients. Interestingly, Jacobson and colleagues (2009) stated that "the city is the setting for multiple dignity encounters between individual and collective urban residents" (p. 731). The authors went on to contend that dignity is a determinant of health in urban contexts. There is a strong argument for a more critical examination of how urban design facilitates oppression and dignity violations.

Inclusion is another theme in the MHCC's 2015 guidelines. Urban design practices can serve to either include or exclude people. One alarming trend in urban design is the practice of defensive or hostile architecture (Quinn, 2014). Municipalities all over the world are using design as a method for exclusion (see photos on this page). Benches in public spaces are designed to be uncomfortable to sleep on or even sit on for long periods of time. In some extreme cases, "homeless spikes" are installed to stop people experiencing homelessness from sleeping in front of buildings. These design practices embody the "othering" that the recovery model of practice actively advocates against.

Looking at the six dimensions of recovery-oriented practice established by the MHCC (2015), we can see where there are implications related to the environment as we understand it from the perspective of occupational therapy. Environments contribute to how people see themselves; if an environment is designed in a manner that strips the dignity of those who inhabit it, how can we expect to create a culture of hope? Furthermore, how can built environments recognize the diversity of those who access them? Finally, we must recognize that transforming systems and services does not end with the health-care system. Other systems, such as municipal governments, play a role in promoting recovery-oriented environments. The opportunity is there for occupational therapists to help build and advocate for places and spaces that promote recovery.

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Defensive architecture. Photo credit: Nils Norman. #dismlagarden http://www.dismalgarden.com/archives/defensive_architecture

Update on Action Over Inertia: Research and practice

Megan Edgelow

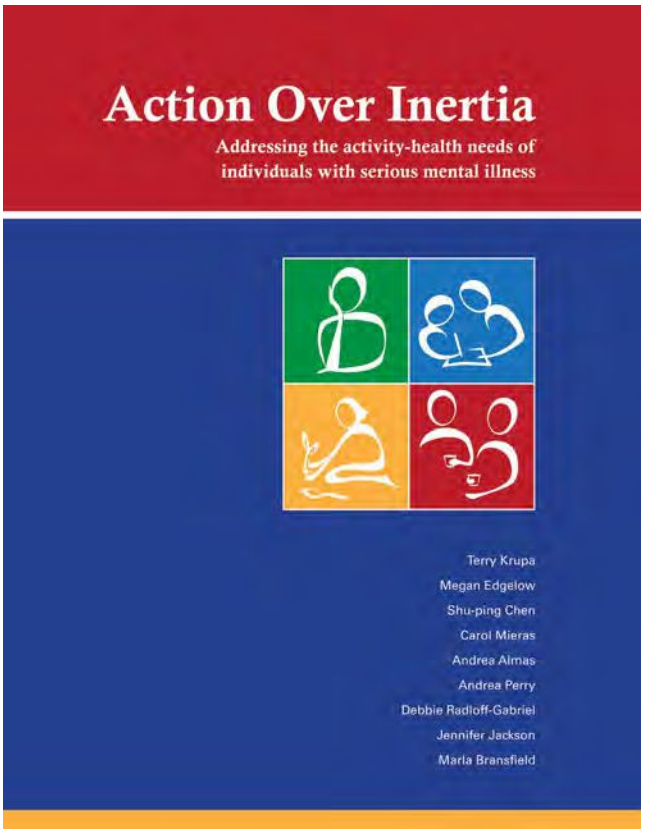
In 2007, in Kingston, Ontario, a group of occupational therapists passionate about the community lives of people with serious mental illness designed a workbook they could use with clients who experienced barriers to full activity participation. The result of these efforts was the published time use intervention, *Action Over Inertia* (AOI; Krupa et al., 2010). The AOI workbook uses the theoretical underpinnings of the Canadian Model of Occupational Performance and Engagement (CMOP-E) as well as the recovery model. It also incorporates a time-use perspective with a focus on occupational balance and engagement.

AOI is unique as an intervention in its focus on activity health and participation, articulating the many benefits of daily activity participation and drawing on an existing evidence base related to time use and activity participation. It is focused on the assertive engagement of clients in activity participation and relies on occupational therapists' expertise and reasoning to tailor the program to their clients' needs (Krupa et al., 2010). This approach is congruent with the recovery model in promoting client empowerment and choice, with a focus on supporting well-being for people who experience mental illness (Rebeiro Gruhl, 2005).

Since its publication in English, AOI has gone on to be translated into French, German and Hebrew, with work continuing on a Mandarin translation. It has been sold in 16 countries, most commonly in Canada, the United States and Australia. Training workshops for the workbook have been held across Canada. Several positive reviews of the AOI workbook have been published, including in the *Psychiatric Rehabilitation Journal* (Kinley, 2010), the *British Journal of Occupational Therapy* (White, 2011) and the *Canadian Journal of Occupational Therapy* (Walsh, 2012). Reviewers noted the applicability of the workbook to many areas of mental health practice as well as possibilities for its use with other populations who might benefit from increased occupational engagement.

In 2011, the results of a randomized controlled pilot study of AOI were published (Edgelow & Krupa, 2011). The pilot study included 18 participants who had a serious mental illness and a history of extreme activity disengagement and who were receiving services from Assertive Community Treatment teams in southeastern Ontario. The treatment group increased their time spent engaging in activity by 47 minutes per day, on average, after 12 weeks, a statistically significant difference ($p=.05$). All treatment participants gave positive feedback and stated they would recommend AOI to others with similar challenges; equally positive feedback was received from the occupational therapists who delivered the intervention. Some of the changes in time use seen during the study were normalized sleep patterns; participation in volunteer work, leisure activities and social programming; improved home management and increased participation in spiritual activities.

Research has continued in other contexts. In 2015, four student occupational therapists at Queen's University partnered with Dr. Terry Krupa to investigate the Activity Engagement Measure, an outcome measure embedded in the AOI workbook. This measure is organized around key elements of occupational engagement, including occupational balance, physical activity, structure and routine, meaning, satisfaction, social interactions and accessing community environments (Bejerholm, Hansson, & Eklund, 2006; Bejerholm & Eklund, 2007). Twenty-five individuals with serious mental illness and the same number of individuals from the general population completed the measure. Results showed that there was expert agreement related to the experience of health through activity, it has good internal consistency and acceptable test-retest



reliability. Results are currently in preparation for dissemination.

Also in 2015, the Do-Live-Well framework was published (Moll et al., 2015). This new Canadian tool was developed by occupational therapists to demonstrate the link between activity patterns and health and well-being outcomes. The framework uses a health promotion approach to empower individuals to reflect on their activity patterns and health and to optimize their patterns of activity engagement. AOI contributed to the theoretical formulation of this framework as one of seven occupational therapy sources used in its development (Moll et al., 2015).

There are several Canadian and international studies on the clinical application of AOI in various stages of design, data collection and data analysis, and more information will be available when results reach the dissemination stage.

The primary authors of AOI are regularly contacted by occupational therapists inquiring about the use of the workbook for populations other than those with serious mental illness, for whom it was initially designed. Since 2014, groups of student occupational therapists at Queen's University have been working with this author to design new content that builds on the time-use approach and is tailored to a variety of populations. To date, new content has been written for people who experience anxiety, post-traumatic stress disorder, dementia and chronic pain, as well as for at-risk youth. The development of new content related to mood disorders, intellectual disability and acquired brain injury will continue into 2017, with the goal of publishing an add-on package that extends the original content to address additional occupational engagement issues.

Since the development of AOI began in 2007, much progress has been made on the publication and dissemination of the workbook and related research. The authors of AOI hope that their example of collaboration with the goal of developing a tool to increase activity participation for their clients, and a view to client recovery, can inspire other occupational therapists to take similar approaches in their practices.

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Prosper Place Clubhouse: A mosaic of inclusion for recovery

Heather Bussiere, Bluma Goldberg, Loraine Kolber, Helen Tam and Esther Wong

The recovery philosophy is being embraced by the mental health community as a means of guiding practice and promoting psychosocial rehabilitation principles while recognizing values such as personal uniqueness, self-determination, strengths and responsibility (Mental Health Commission of Canada, 2015). Prosper Place Clubhouse in Edmonton, Alberta, is an example of an organization that applies recovery principles to practice. Helen Tam and Esther Wong are second-year student occupational therapists who completed a fieldwork placement at Prosper Place Clubhouse. This article uses excerpts from Helen and Esther's journaling and discussions to reflect on how the philosophy of recovery and psychosocial rehabilitation principles are expressed in the daily operation of this clubhouse. The authors also reflect on how the philosophy and principles of the clubhouse mirror the values of occupational therapy.

The clubhouse model

Established in Edmonton in 1997, Prosper Place Clubhouse is a member-driven community mental health day program that welcomes any adult living with a primary diagnosis of mental illness. It is modeled on the original clubhouse, Fountain House, which was established in New York City in 1948. Today, clubhouses worldwide operate under the belief that a clubhouse "provides a restorative environment for people whose lives have been severely disrupted because of their mental illness, and who need the support of others who are in recovery" (International Center for Clubhouse Development d/b/a Clubhouse International, 2016, "What is a Clubhouse," para. 2).

Clubhouses, such as Prosper Place, offer opportunities to develop a sense of belonging and engage in meaningful and productive activities. Participants are "members" and are welcome to attend as frequently as they like, with attendance being voluntary and without time limits. All members participate in the operation and policy decisions of the clubhouse, direct their participation in daily activities and are not defined by their illness or diagnosis. Ultimately, Prosper Place Clubhouse is a community of staff and members working collaboratively to keep the clubhouse running while members are simultaneously actively engaging in their own recovery.

Helen wrote: "I quickly realized that knowing their diagnosis meant very little to my understanding of the members. I would rather read about their interests, goals, families and just things that matter to them. We say time and time again that your mental illness or disability does not define you, but I never really understood that concept until today."

Prosper Place: The clubhouse model in practice

The path for recovery, as identified by the Mental Health Commission of Canada, is guided by hope, dignity and inclusion (2015). The values of dignity and inclusion are embodied within the clubhouse model. Members are soley defined by their individual contributions and unique qualities. Staff participate and work alongside members as colleagues in completing daily clubhouse tasks. Mutually respectful and equitable relationships serve to support members to feel invested in, rather than the recipients of, services. The third value, hope, is fostered through members' opportunities to share in each other's daily successes and achievements. In this way, members see others in various stages of their unique recovery journeys and gain inspiration and motivation.

Prosper Place offers three main programs. These include the work-ordered day, supported individual and group employment, and social recreation and educational activities.

The work-ordered duties centre around completion of administrative and business tasks, including publishing a monthly newsletter, operating a café, running a canteen and thrift store, and doing general maintenance and upkeep of the clubhouse. Through program participation, members identify and cultivate their strengths while acquiring the tools to shape and take responsibility for their own recovery and reaching their potential. Prosper Place also encourages and supports members to take on volunteer positions and community, individual or group employment if they wish. These opportunities offer the members real work in inclusive environments that help to break down the stigma associated with mental illness in the community.

Esther observed: "It is wonderful that a place exists for individuals to build their skills from the ground up and have the chance to begin believing in themselves, their skills and their worth."

Socialization is part of the daily routine of the clubhouse. In addition, recreational activities are offered on a regular basis, which can include sharing meals together and celebrating holidays and other special events. These shared experiences are pivotal in developing a sense of belonging, safety and acceptance that may not be present in other aspects of the members' lives. They also offer opportunities for friendship and fun.

Esther wrote: "I can already see that the members of the clubhouse aren't merely acquaintances but that some of the members rely on the clubhouse as their sole source of social support. As I am getting to know the members more, I can see how valuable this clubhouse is to them and how it has changed their lives."

The clubhouse also offers members workshops supported by community professionals, for example, art therapy, creative writing and drama club. Student occupational therapists aim to enhance educational components of the programming and this has become an integral part of the students' role at Prosper Place. Helen and Esther prepared and delivered a variety of educational workshops relating to meaningful daily activities (occupations), designed to inspire and bring joy to the members, while also enhancing their own professional learning.

Helen noted: "As I got to know the members, I was blown away at how important this centre is to the community. I can't imagine how else the members would learn essential skills, transition back into the community or have a safe place to go to every day."

The students' reflections on their experience

One of our priorities during our fieldwork placement was to promote and advocate for the occupational therapy profession by explaining our unique skillset. We took time to share with members and staff the relationship between engaging in meaningful daily activities and the promotion of health and wellness (Krupa, 2010). During education sessions, we also strived to address the health and activity needs and interests of the members and were surprised at the breadth of what occupational therapy could offer, as demonstrated by the diversity of education topics covered. Topics that we offered the members included effective communication, self-esteem, diabetes and foot care, and sexuality.

In providing education sessions, we learned the power of peer involvement for enhancing the learning process. For example, our presentation on intimacy and sexuality was our most successful presentation, and also the one we were most anxious about. During this session we asked the members to create a script on how to disclose their mental illness to a partner. While we facilitated the session, the members were equal partners in the process by answering each other's questions with knowledge from their own experiences. We quickly realized that we could not help members as effectively as they could help each other; we did not know what it was like to be in their shoes.

At the end of our clinical placement, we decided to create a sunflower mosaic with the members of the clubhouse as a celebration of our time there. At Prosper Place, members and staff alike feel valued for their differences and the unique skills and insights that they share with the clubhouse community. This diversity, represented by the pieces of the mosaic, represents something beautiful—a community of acceptance, respect and inclusion. Prosper Place is an inspiring example of how occupational therapy practice, psychosocial rehabilitation and recovery can harmonize to promote health and wellness.

Mosaic completed by students and members of Prosper Place at the completion of the occupational therapy student placement.

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Let's get together: Fighting loneliness for a healthier society

Rehana Hirji

When considering human needs, basic needs (food, clothing and shelter) are often the first to come to mind. However, as inherently social beings, we also have a fundamental need for human connection.

Loneliness, the subjective experience of limited meaningful human interaction, can be a product of social isolation (a physical state of isolation, in which individuals spend much of their time alone) or emotional isolation (feeling emotionally alone despite the physical presence of others; Weiss, 1973). A growing body of evidence shows that loneliness and social isolation are risk factors for coronary heart disease, stroke and mortality (Holt-Lunstad, Smith, Baker, Harris, & Stephenson, 2015). In *Changing Directions, Changing Lives: The Mental Health Strategy for Canada,* isolation is indicated as a risk factor for mental illness (Mental Health Commission of Canada, 2012).

In my practice, I have observed how loneliness can be a roadblock to recovery. Individuals who struggle to have meaningful connections often face challenges to engaging in their recovery. This experience is compounded by stigma, high unemployment rates and overall low levels of meaningful time use. The following includes a summary of my reflections on how isolation and loneliness occur and are addressed in practice, as well as suggestions for the roles of occupational therapy, mental health services and the community as a whole to address the causes and consequences of loneliness.

During the process of recovery, the illness itself may contribute to isolation. For example, a sick leave from work may result in a person being disconnected from colleagues while he or she stays home to recover. An extended leave from work may result in being released from work, social or relationship problems at home and a perpetual cycle of isolating oneself.

Occupational therapists can have a significant role in helping individuals with mental illness look at loneliness as an important indicator of health and recovery. They can engage clients in conversations about time use, meaningful relationships and activity participation. As well, occupational therapists are well equipped with the relevant training and tools to take a leadership role in incorporating assessment of and interventions for loneliness into every day mental health service delivery.

In its *Guidelines for Recovery-Oriented Practice*, the Mental Health Commission of Canada (2015) recognized that stigma related to mental illness can also contribute to isolation for people. The community has a role in promoting stigma and minimizing the potential of people with mental illness to fully participate. Anecdotally, people with lived experience of mental illness identify many factors contributing to their loneliness, including poverty, estranged or geographically distant familial relationships, decreased contact with faith-based communities and difficulty meeting new friends in adulthood.

Connections and engagement are important for the health of all community members. Whether living with a mental health problem or not, opportunity should exist to participate wholly if that is a person's desire. It is important that we ask our clients if they are lonely and offer to address loneliness as a goal for occupational therapy intervention.

As a society, we have a responsibility to address loneliness in order to support mental health and promote recovery. While some efforts directly or indirectly help to address isolation, such as social recreation centres that include individuals with mental illness, or Meetup.com (a website where individuals can arrange to engage in in-person group activities or discussions with others in their community), loneliness persists. Inquiry into the limitations of these efforts, including the scope or breadth of resources, as well as barriers to access, is necessary to inform future efforts.

Occupational therapists are well suited to address these limitations by creatively targeting the gaps in both societal and recovery-focused initiatives to optimize fit with individuals' needs. The particular interventions and strategies enlisted may include increasing social recreation initiatives, continuing to address mental illness stigma, augmenting education about the importance of social connection and the nature of healthy relationships, or reinforcing a stronger sense of community for all. The goal is not only to limit social isolation, but also to optimize the quality of interactions to address emotional isolation. Ultimately, we need to come together as communities across Canada to address isolation and recognize its impact on mental illness, recovery and the health of all Canadians.

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A student occupational therapist's reflections on recovery as seeing and being seen

Genna Solomon and Hiba Zafran

In this article, the use of the term "I" relates to the first author's experience and has been maintained throughout the text. The second author contributed to reflectively framing this experience within the theoretical and empirical literature.

Two weeks into my mental health fieldwork placement as a student occupational therapist in a transitional day program, I met a client with a complex personal history whose mannerisms, words and tone conveyed to me a sense of deep sorrow and isolation. Her apparent struggles reminded me of my own darkest episodes, when striving to express myself in a rational way took unbelievable effort, making me feel worthless, alone and misunderstood. Had I been in the client's place then, I would have wanted to know that I was not alone, and that there was hope for things to change. I believed that if she knew she was talking to someone who could comprehend the enormity of the demons she faces, she might feel less alone.

I decided to relay a small nugget of my personal experience, explaining that change is a slow process but it does happen, and that I know this because it happened for me. Upon hearing this, the client appeared relieved, her face relaxed and she smiled a little. A key element of recovery is connectedness (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011), including connection with health-care professionals. Mental health care is not a one-way street where only the client feels understood; rather, it is a mutual regard (Fraser, 2000) wherein both provider and client are in a professional and genuine therapeutic relationship. I felt we developed an understanding that both she and I were in this together. My fieldwork supervisor commented on how I was able to use my personal experiences in an appropriate and effective manner. In the weeks that followed, the client disclosed that she felt increasingly safe to talk with me, and shared that our discussions had motivated her to take steps toward making changes in her life. Although I have no way of knowing whether my support had any lasting impact for her, I do know that my choice to briefly open up helped her feel connected to another person, and that it fostered a shift in her vision of possibility for her future.

The team with whom I worked comprised experienced and caring professionals, yet I noticed that these qualities alone did not necessarily translate to the development of relational partnerships (Jacobson & Greeley, 2001), an essential element of recovery-oriented care. I observed that judicious disclosure of relevant information embodying the notion of a shared journey of growth and discovery (Slade, 2009) was not the norm within a model of biomedical expertise. Further, I observed that stories about past service users were told on occasion with a judgmental or flippant tone, including comments such as, "With so much money and social support, what is she depressed about?" The attitudes underlying these kinds of conversations struck me as stigmatizing, and I wondered about their impact on caring practices in this setting.

In general, I believe that in an environment where the tenets of recovery-oriented care are applied, stigma can be challenged and explored respectfully (Pickles, 2014; Pietrus, 2013) through dialogue. As occupational therapists, we have an important role as change agents who educate and advocate (Canadian Association of Occupational Therapists, 2012). Demonstrating self-acceptance to colleagues can be beneficial in questioning stigmatizing assumptions, and I am learning that the words and actions we use around self-disclosure may also colour their impact. For example, if I say I am "sharing" parts of my story as a means to foster hope, I may be taking on a role akin to that of peer support worker, which includes a type of reciprocity characteristic of mentors or friends (O'Hagan, Cyr, McKee, & Priest, 2010). If I use the term "judicious self-disclosure," it may indicate a deliberate choice to use personal experiences toward a therapeutic purpose, which may be more in keeping with an expert role or may be associated with the medical model.

Advocacy can take many forms, and I believe that sharing selective personal realities can have a powerful impact on normalizing mental health issues and promoting compassionate, respectful and accepting attitudes toward persons with such challenges. When asked directly about my medication and treatment, I chose not to answer, as I believe this disclosure would not have helped the client make informed decisions about her own care. In all situations and practice settings, I must consider whether personal disclosure is the most effective strategy for a given issue. Timing, cultural and therapeutic safety, mutual trust and respect, and my professional reputation are all important considerations. To this end, the authors propose a series of reflexive questions that

may help occupational therapists gauge the value of personal sharing with a client:

- Will this help the client right now? In what way?
- Why do I want to share? Is this my need to be seen or connect?
- Which pieces do I share? When?
- Could this information be negatively misinterpreted by the client?
- Is sharing or education best for the client right now?
- How was the information received by the client? Was it helpful?
- How do I continually appraise the effects of sharing?
- How might sharing with one client impact other professional relationships in the health-care setting?

It is not uncommon to question whether disclosing one's history with fluctuating mental health poses a risk to professional credibility (Carter & Motta, 1988). However, if normalizing mental health challenges is part of our role, then how can health-care professionals expect clients to believe there is no shame in living with mental illness when those of us with comparable life experiences keep them entirely separate from our professional lives? How can we advocate for dispelling stigma through authenticity, applying this standard to others but not to ourselves? By communicating aspects of my experiences of anxiety and despair, alongside positivity and hope, I have been able to connect with clients and professionals in a unique and powerful way. Many of the clients in the program thanked me for my contribution to their recovery process. As some of them told me on my final day of the fieldwork placement, my willingness to share relatable portions of my lived experience made them feel understood, valued and supported.

When practiced with discernment and critical reflection (McCorquodale & Kinsella, 2015), sharing one's personal truths can foster meaningful connections and empowerment in others. In sharing my student perspective on being "seen" as a strategy for connection and advocacy, and as a part of recovery-oriented practice, my hope is that others will begin to question their assumptions and perceptions regarding boundaries between the personal, the professional and the political, and evaluate the significant benefits to making some room for vulnerability in their practice.

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Cover image credit:

Photo by Hina Mahmood

Hina says: "This image represents the value of mindfulness meditation and how it can contribute to recovery and quality of life. Occupational therapists can incorporate this practice into client-centred care, providing a means of empowerment and personal control over healthy lifestyle management."

Field notes: A candid look into the conversations of student occupational therapists during mental health fieldwork placements

Nicole Matichuk and Liv Brekke

What do hope, person-centredness and a strengths-based approach to care look and feel like in real-world occupational therapy practice? And how do the values and competencies of psychosocial rehabilitation and recovery-oriented practice emerge organically in the discussions of student occupational therapists during fieldwork placements? This article provides a glimpse into the authors' one-to-one instant messaging conversations as student occupational therapists completing mental health fieldwork placements.

One of us was placed in a community-based day program for adults, while the other was located in a province-wide in-patient and outpatient program for people with eating disorders. Throughout our seven-week placements, we spent significant time debriefing and providing mutual support about our experiences via instant messenger. Excerpts of these conversations are provided in italics below according to themes that emerged, along with our subsequent reflections on these topics. By sharing this information, we hope to provide an authentic glimpse of our challenging and exciting journey into occupational therapy, psychosocial rehabilitation and recovery-oriented practice.

> "Recovery is a journey not only for people living with mental illness and their families but for everyone involved in providing support and service" (Mental Health Commission of Canada, 2015, p. 17).

A complex beginning

-How's placement this week?
-Good! I still feel terribly inadequate but I'm loving mental health more and more. How about you?
-Samesies. I think mental health is the most challenging but also the most interesting practice area yet. I thought I knew how to interview. Until today.
-I totally agree.

From the start, we both realized that these placements were the most difficult and complex we had yet experienced. All the skills we thought we had come close to mastering suddenly required a whole new level of flexibility and sophistication. Although we had received formal instruction and training in interviewing, building rapport and therapeutic use of self, this felt insufficient. Over the course of our placements, we questioned why this was the case. Were clients more medically, psychologically and socially complex? Multiple coexisting health challenges were common, and clients faced a multitude of social and economic barriers that at times seemed insurmountable. However, upon further reflection we realized that it was not the clients themselves who were more complex, but rather that we had the time and the opportunity to gather a more holistic picture of our clients' experiences. We also reflected that this was likely the result of the clear emphasis on person-centredness that we experienced in both hospital and the community.

We also discussed the challenges and rewards of engaging in motivational interviewing (Miller & Rollnick, 2013). Although we both recognize the value of motivational interviewing in eliciting hope and promoting autonomy, it was not always an easy tool to use. In one setting, seeking answers and change from clients felt difficult, at times like "pulling teeth." It would have been easier to share what we thought was best. However, on the occasions when we were able to help elicit meaningful goals and plans from clients, we could see the change in them. For example, one client felt they had lost a part of their identity when they stopped volunteering. Through discussion, this client came to the realization that there was nothing preventing them from returning to volunteering. Their face lit up with excitement. Seeing a client progress toward a goal they identified as a priority for themselves, no matter how small, felt like a great triumph. It also reinforced for us the power that comes with clients finding their own desire to change and setting their own goals. Motivational interviewing helped us experience person-centered practice and the power of hope first-hand. Seeing the successes of this approach has become one of our biggest motivators for continuing to learn about and work in mental health settings.

Building collaborative partnerships

-Are you enjoying mental health?
-The lowering of personal boundaries is definitely an adjustment, but yeah I could see myself doing this.
-Lowering of personal boundaries?
-Like not reinforcing the patient-therapist power dynamic—no name tags, eat lunch with clients, more casual attire. And lots of small talk.

The increase in the perceived complexity of our mental health fieldwork placements also extended to the experience of building collaborative partnerships. Being effective in the community-based setting required drawing on these more extensively. It necessitated a lowering of typical personal boundaries, which was new and somewhat uncomfortable territory. There were many opportunities to work alongside clients as equal partners. This meant being willing to share personal information, to a certain degree. Here, the fieldwork supervisor was an important role model, as her approach to information-sharing served as a guide. Sharing with clients became more natural as the placement progressed and reinforced the importance of non-clinical interactions for building rapport. These genuine conversations built the foundation from which to engage with clients and from which they could proactively engage with us, by creating a welcoming and non-judgmental environment.

Shared experiences

-Have you ever over-identified with a client? I had a client last Friday who reminded me a lot of myself.
-Frequently. It's a little scary.
-I suppose it can make you a better a therapist, though. Lived experience is an asset, right?

-Do you ever find it hypocritical to be helping clients challenge their belief that they need to be perfect?
-Um yes. For me, self-compassion is definitely a challenge. Also ruminating and black and white thinking.

In general, we felt that the therapist-to-client connection was very rich. It was an emotional process to see and feel where clients were coming from in their own lives. Learning about mental illness is one thing, but being in the moment and experiencing how it impacts the lives of clients is a different thing entirely. Our clients taught us about and allowed us to witness determination, relapse and resilience. The depth of our connection with clients and their willingness to share their experiences were unexpected and rewarding parts of the learning experience.

We also both felt that we could see pieces of ourselves in the clients with whom we were meeting, like the anxious, driven, perfectionist student and individuals struggling with their body image. At first this experience was somewhat disconcerting; we perceived it to be a negative thing to "over-identify" and did not want to minimize the client's experience by trying to equate it to our own. However, there was also humility and power in realizing our common humanity in this way, and we believe this realization has helped us become better therapists.

Similarly, we also recognized the difficulty of the work undertaken by individuals recovering from mental illnesses. As therapists, we might encourage clients to practice self-compassion, build fun into their daily lives or monitor and challenge difficult or negative thoughts. Yet most people, us included, never spend this amount of time and energy dedicated to working on our mental health. One program manager very astutely pointed out that the best therapists have tried to practice the various techniques that they recommend or work on with clients. We see this as an area for ongoing improvement and learning for ourselves.

Occupational therapists as recovery coaches

-How was your week?
-Not too bad. I feel so much less confident this placement though.
-Agreed. It's the counselling role that gets me.
-Yes!

-How was your day?
-Ok. I feel like a bad therapist but I guess that's learning.
-Why do you feel like a bad therapist?
-Because I never know what to say to people. For some reason, talking through problems is so much tougher than working through them physically.
-I totally agree. At times I feel like an awkward turtle.

-I just spent 1 hour 50 minutes with a patient. Epic redirection fail.
-How so?
-They were very tangential. And I always feel like I'm being rude when redirecting.
-Ah I see. I think a lot of us struggle with that.

Throughout our placements, we both watched our supervisors act in a coaching role with clients and we often felt unprepared to do the same. Clients often came to our supervisors for advice on specific problems. We both observed our supervisors speaking to clients, listening to them actively, and offering appropriate and measured guidance. When faced with the challenge of doing this ourselves, we were concerned that we were doing the clients a disservice because of our lack of expertise. We were also often afraid of saying the "wrong" things to clients.

On one occasion, a supervisor challenged this type of thinking directly. She stated that, after watching and listening to the student interact with clients, she did not believe it was possible for the student to say anything damaging. The supervisor went on to highlight that, no matter what you do, people can twist and change things you say in their minds. But, if you are actively listening and offering support, it is unlikely you will say something that will be interpreted as harmful. In other words, if our intentions and approach to client interactions are appropriate and well-meaning, this is likely to carry through into our words.

In hindsight, it is possible that our fear and lack of confidence stemmed from our perceptions of the nature of working through mental health challenges. We couldn't necessarily "see" the effects of our intervention; that is to say, we could not know what was going on inside the minds of our clients. For example, we might not know if something we said led a client to ruminate long after a conversation. In a way, it felt like we were less able to receive immediate feedback on our performance, which led us to be less likely to trust

ourselves. However, upon further reflection, we realized this inability to see into the minds of our clients is no different from other placements. Instead, we recognized that our words and language were particularly important in this setting. With more time and experience, we have both begun to feel more prepared to step into the "occupational therapist as recovery coach" role. By continuing to challenge our perceptions, we will be able to draw on these skills more fully in future practice.

Lasting impressions

-I feel so motivated! I feel like I could stay for another 7 weeks.
-That's so great to hear!! And I totally concur with that.
-I can't believe it's almost over. Time flies.

Our respective placements left us feeling passionate about the possibilities for occupational therapy in mental health. In particular, we are excited to continue to learn as much as possible to better serve our clients. The mental health setting ignited our "research brains" by revealing many unanswered questions and potential enhancements to service delivery. How can we better measure progress in our respective settings? How can program development and outcome measures better serve this client population? The possibilities for future learning and study in the area of recovery and mental health feel vast and exciting.

Overall, completing mental health fieldwork was a transformative experience. It deepened our appreciation for those who practice occupational therapy in this area, and sparked the realization that the recovery and psychosocial rehabilitation skills we honed could apply to any setting. We have learned the value of taking the time to get to know clients holistically and of engaging them in collaborative goal setting and treatment planning that is meaningful and evidence-based. In a short time, we observed how hope, open communication and inclusion are powerful means for developing a therapeutic relationship that can have transformative outcomes. As emerging occupational therapists, we both agree that our fieldwork experiences will forever change how we approach and interact with all future clients. Having the opportunity to learn and practice in these two unique mental health settings has been invaluable and made us not just more reflective, sophisticated future therapists, but also better human beings.

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Students' reflections on recovery in research and clinical practice: Lessons learned and unanswered questions

Alissa Low, Christine Daniel, Catherine Auger, Rachel Kadoch, Suzanne Rouleau and Laurence Roy

In the past decade, mental health policies in Canada have shifted toward recovery-centred approaches (Mental Health Commission of Canada [MHCC], 2012; MHCC, 2015). As students in a professional master's program in occupational therapy, the keywords or concepts of recovery, such as those of the CHIME model: connectedness, hope and optimism, identity, meaning and purpose, and empowerment (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011), offer direction for our mental health practice. With these ideas in mind, we welcomed the opportunity to spend the summer of 2015 conducting a research project consisting of interviews with adults who experience severe mental illness attending a recovery-oriented outpatient program. The interviews offered insights into what recovery means for participants and extended findings of other studies examining the relationship between occupation (meaningful daily activities) and mental health recovery (e.g., Kelly, Lamont, & Brunero, 2010; Lloyd, Wong, & Petchkovsky, 2007). This paper focuses on some unexpected learning with regard to our efforts to do recovery-oriented research. Throughout this paper, we will explore two facets of this experience: first, the ethical tensions we faced, and, second, how questions related to the integration of research and practice were left unanswered.

Ethical tensions

Considering the degree of "moral complexity of contemporary professional practice" (Kinsella, Park, Appiagyei, Chang, & Chow, 2008, p. 176) in mental health service delivery, it may be not surprising that we experienced both micro-level and macro-level ethical tensions during our research endeavour. At the micro, or interpersonal, level, we noted two complexities when preparing our study. The first complexity aligned with Lal's (2010) critical perspective indicating that one's worldview influences one's use and understanding of the term "recovery"; thus, we reflected that our ideas of recovery were influenced by our curriculum material. More specifically, one of our readings from Leamy et al. (2011) described recovery as a personal experience, rather than a series of measures imposed on individuals by the mental health system. We were also influenced by the writings of Patricia Deegan, who posited that "recovery is a process, not an end point or a destination. Recovery is an attitude, a way of approaching the day and the challenges I face. . . . I know that I have certain limitations and things I can't do. But rather than letting these limitations be an occasion for despair and giving up, I have learned that in knowing what I can't do, I also open upon the possibilities of all the things I can do" (Deegan, 1997, pp. 20-21). As cautioned by Drake and Whitley, the second complexity consisted of the possibility of recovery as a new "catchphrase" (2014, p. 237), as new approaches may sometimes replicate traditional ways of providing mental health services.

Thus, at the micro level, with these perspectives of recovery in mind, we attempted to minimize our influence on research participants' definitions of recovery. One strategy to reduce our influence was to omit the word "recovery" from interview questions. However, we found that the use of our learned biomedical language was deeply ingrained into our world view and it quickly became default language in situations of uncertainty. For example, in an attempt to describe recovery in some interviews, we compared the recovery process for mental illness to the recovery process for a broken wrist. We soon realized how our unintended use of language influenced the conversation before we were able to truly hear participants' perspectives of recovery. As we considered the interplay between the micro and macro (systems-level) perspectives, we were left with the unanswered question of how mental health service providers actually use the language of recovery, as "the language of recovery may not be seen to reflect people's historical, linguistic or cultural background and experience" (MHCC, 2015, p. 10), and recovery aims to "[represent] the interests of people living with mental health problems and illnesses, to ensure that their voices are heard" (MHCC, 2012, p. 121).

From an organizational-level perspective, an ethical tension was identified by participants regarding interest in having an informal social space in the outpatient department for use during the discharge transition process in or out of the hospital. Some participants expressed that social connections were made in the outpatient department, however, they did not feel ready to access similar informal services within a community setting. Tew (2013) established the therapeutic benefits of belonging and engaging socially as ways to reclaim ownership of one's life–our participants showed us that realizing this sense of belonging can be difficult to achieve in a community setting. Interestingly, Slade et al. (2014) expose an "abuse" of the recovery orientation in eliminating services that are institution-based toward a more community-oriented setting. We were faced with the dilemma of which voices to listen to. Should there be an informal, social space in the outpatient department when such spaces are offered in the community? Even if there was consensus on the benefits of an informal social setting at the outpatient department, there

would not be enough resources to make this happen due to recent budget cuts. Given this constraint, we wondered if this identified need could be met in other ways.

This scenario leads to one final, macro-level ethical tension that highlights the dilemma faced by recovery-oriented programs that lack the resources to move beyond individual-level interventions. We empowered participants to voice their desires for services that they believe will promote their personal recovery, yet we are not empowered ourselves as clinicians or researchers to be able to offer these services. For example, how do we reconcile the need for participation in paid work or community-based activities (e.g., arts), as discussed in the recovery literature and in the narratives of participants, with the inability to implement evidence-based recovery-oriented interventions such as individual placement and support, or access to peer support (Slade et al., 2014)? Thus, what becomes of our support for recovery interventions if our work with individuals is unable to actualize what Deegan (1997) describes as "the possibilities of all the things I can do."

Integrating research and clinical practice under a recovery framework

Our study prompted us to reflect on the research process itself as a strategy to remain critical of our own recovery orientation. As future practitioners, we argue that putting in place mechanisms that allow for continuous engagement in research in our workplaces is crucial for the development of professional skills such as critical reflexivity and advocacy. What could these mechanisms look like? We believe there is a need for more discussion about the value of research in everyday occupational therapy practice and about the responsibilities of practitioners, employers and universities in fostering this integration of research and clinical practice. Such integration would allow practitioners and clients to explore and discuss in greater depth, among other things, macro- and micro-level ethical tensions such as we observed in our study. By conducting our research study, we were able to develop a critical perspective on recovery, apply reflexivity, and experience, firsthand, ethical tensions that occurred in doing recovery-oriented research. Further, we are now more aware of the need to take the time to listen and allow clients to direct their own recovery in their own language. As new occupational therapists, we hope to continue practicing critical reflexivity and seeking perspectives of people with lived experience, relating to both individual- and systems-level matters. The complex question of how to advocate for such tight integration of inquiry and practice remains a topic for future discussion.

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The intention of this special issue of *Occupational Therapy Now* is to provide a broad audience, including occupational therapists, health professionals, clients, policy makers, the general public and other stakeholders, with information on the role of occupational therapy in recovery-oriented psychosocial rehabilitation. This issue is open access and available online at: http://www.caot.ca/default.asp?pageid=4074 Please share this link widely!

Moving from reflection to action: Exploring practices of reconciliation in recovery-oriented practice

Colleen McCain

Recently, I began working in a position with a regional health authority, partnering with First Nations organizations and communities to develop mental wellness and substance use services based in reciprocal learning, cultural safety and Indigenous perspectives of wellness. To effectively enter this work as a woman of European ancestry with an urban, middle-class upbringing and access to graduate level education, I began to actively engage in a journey to explore what reconciliation looks like in the context of my personal and professional life. I began exploring how I, and the mainstream mental health services within which I work, can integrate practices of reconciliation, cultural safety and respect into our partnerships with Indigenous individuals, families, communities and organizations. The following commentary will highlight the contributions of the Truth and Reconciliation Commission (2015), the *Guidelines for Recovery-Oriented Practice* by the Mental Health Commission of Canada (MHCC; 2015) and occupational therapy literature in exploring pertinent practices of reconciliation for occupational therapists.

The Truth and Reconciliation Commission of Canada (TRC) defines reconciliation between Indigenous and non-Indigenous peoples in Canada as an "ongoing process of establishing and maintaining respectful relationships" (2015, p. 16) to support the ongoing healing, strengthening and revitalization of Indigenous cultures, languages, identity and governance within Canada. The TRC calls on Canadians to "practise reconciliation in our everyday lives—within ourselves and our families, and in our communities, governments, places of worship, schools, and workplaces" (p. 21). The TRC process and the Calls to Action listed in its final report are crucial steps in acknowledging our country's history of assimilation policies and initiating an overdue transformation in our relationship with Indigenous peoples (TRC, 2015). To embrace the TRC Calls to Action is to embrace professional accountability to learn about the history and the ongoing impacts of colonization on Indigenous peoples today. For Canadians in general and occupational therapists in particular, these recommendations identify the need to understand that the health inequities faced by Indigenous peoples are directly related to racism, intergenerational trauma and disruption of culture resulting from the legacy of colonization policies and attitudes in Canada (TRC, 2015).

As occupational therapists, we are just beginning to reflect critically on our practices and to find ways to connect them to reconciliation. Authors such as Hammell (2013) Gerlach (2012, 2015) and Beagan (2015) have introduced key concepts of cultural safety, cultural humility, de-centring and intersectionality of identity into the occupational framework of health and well-being to evoke a critical review of our professional models, assumptions and values. For example, Beagan (2015) challenged us to reach beyond cultural competency and explore the dynamic nature of cultural humility to engage in a critical examination of our own professional assumptions and beliefs as well as personal cultural and colonial heritages of power and privilege. If we do not engage in these reflective practices, if we resist reciprocal learning and exclude diverse cultural perspectives and practices, we run the risk of inadvertently perpetuating colonial power relations. This in turn may result in a disempowering experience of health care for the very people for whom we want to support wellness (Gerlach, 2012).

The MHCC is committed to reconciliation with First Nations, Métis and Inuit peoples in Canada (MHCC, 2016). The *Guidelines for Recovery-Oriented Practice* (*Guidelines*; MHCC, 2015) include a chapter focusing on the practices of reconciliation that are foundational to recovery-oriented practices in partnership with Indigenous individuals, communities and organizations. "Chapter 5: Working with First Nations, Inuit and Métis" outlines the core knowledge, values, attitudes and reflections crucial to working in partnership with the three Indigenous groups of Canada, as well as urban Indigenous populations. The *Guidelines* are a resource that supports the critical examination of professional practices based on the cornerstones of cultural safety, cultural humility, reciprocity and self-determination, and approaches that support cultural diversity in health, wellness and occupational

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therapy services. Included in the *Guidelines* is a list of resources to support mental health practitioners' learning related to the Indigenous groups of Canada. The *Guidelines* (2015) challenge recovery-oriented mental health practitioners to ensure people have the choice of a combination of Western and traditional/cultural services while respecting each person's "understanding of culture as the foundation of wellness" (MHCC, 2015, p. 68).

Although progress has been made within the profession of occupational therapy, more attention to the application of concepts such as cultural safety, cultural humility and intersectionality of identity is critical for the profession to be an active participant in the reconciliation process and contribute to the revitalization of Indigenous cultures in Canada and the well-being of Indigenous Canadians. The MHCC (2015) *Guidelines for Recovery-Oriented Practice* demonstrate how the spirit of reconciliation can be practiced in our everyday lives and professional interactions.

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Promoting recovery through annual "Archie Awards"

Matthew Tsuda and Erica Schott

Recovery-oriented services promote important "recovery principles," such as *hope, empowerment* and *connection*, and aim to create a *positive culture of healing* (Jacobson & Greenley, 2001). These are fundamental internal and external conditions that help facilitate the recovery of individuals with mental illness. At the Downtown West Archway Clinic, an outpatient clinic within the Complex Mental Illness Program at the Centre for Addiction and Mental Health (CAMH) in Toronto, we wanted to apply these principles on a program level and in a way that cultivates a culture of hope and healing across our clinic. Thus, we decided to develop an annual recovery awards program, the Archie Awards, which celebrates individual client successes in different areas of recovery.

The Downtown West Archway Clinic serves approximately 430 clients with complex mental illness in west Toronto, providing both Assertive Community Treatment and Intensive Case Management services. In addition to experiencing severe mental health issues, many of our clients also experience many challenges related to social determinants of health (e.g., poor housing conditions, poverty, lack of employment, etc.), trauma, co-occurring substance use and physical health concerns. We have witnessed many clients take significant steps in their recovery journeys and rise above many of these challenges, and we wanted to create an avenue to celebrate these achievements. We also felt that a significant portion of a typical day was spent focusing on "red flag" issues and identifying areas of need for our clients. The awards give us an opportunity to intentionally look at client accomplishments and recognize the many areas in which clients are flourishing.

The Archie Awards is an annual event organized by a small committee of practitioners, including two occupational therapists who serve as co-chairs. Our occupational therapy lens provides us with a holistic and strengths-based framework as we work with clients to promote skill development and meaningful engagement in daily activities. This lens enables us to identify client achievements in many different areas. The awards include a nomination and selection process conducted by practitioners, an awards ceremony and a reception. Clients receive nominations and awards in the areas of:

- Vocation
- Education
- Spiritual wellness
- Peer support
- Healthy living
- Creativity
- Road to recovery (overall wellness)

The awards ceremony includes musical numbers from our client music group, staff guest speakers, a client guest speaker (who shares about his or her recovery journey) and the presentation of the awards. Each award recipient receives a certificate, flowers and a gift card, with nominees receiving certificates too. The event also includes a slide show, with pictures of the award recipients, photos from various client outings and special events throughout the year, and quotations from clients explaining what recovery means to them. Clients, their family members and friends, and CAMH staff are invited to attend the event, and the public affairs department takes photos to highlight all of the winners and their achievements. After the ceremony, we have a small reception, which includes cake, other refreshments, music and dancing. The awards have developed into an important celebration that allows clients, staff and community members to come together to celebrate the hard work and effort that so many of our clients have put into their recovery journeys. It provides an opportunity to encourage clients, build community and combat stigma.

The Archie Awards apply several recovery guidelines outlined in the Mental Health Commission of Canada's (MHCC) *Guidelines for Recovery-Oriented Practice* (2015). Three specific guidelines that the awards particularly endorse are:

1) Promoting a culture and language of hope and optimism
2) Focusing on strengths and personal responsibility
3) Recognizing the value of family, friends and community

Promoting a culture and language of hope and optimism

Part of promoting a culture of hope and optimism includes communicating expectations for positive outcomes and hopeful messages about recovery, as well as affirming beliefs around an individual's capacity to lead a meaningful life (MHCC, 2015). At the ceremony, award presenters share specific examples of how the recipient has demonstrated courage, tenacity and progress toward their recovery goals. There have been stories about clients who have graduated school, persevered with their employment goals despite many barriers, secured improved housing, quit smoking, completed marathon races and other sporting events, and took on peer support or advocacy roles. This acknowledgement is not only an encouragement to the recipient, but also to their co-clients and peers who have the opportunity to hear several recovery stories. Another powerful means of promoting hope is having a client guest speaker share about his or her recovery journey.

Part of building a culture of optimism is encouraging a holistic approach to recovery, including highlighting the importance of social connections, life roles, creative expression, physical activity and spirituality or faith (MHCC, 2015). The awards strive to encourage a holistic approach by acknowledging successes in areas such as spiritual wellness, healthy living and creativity, supporting the idea of thinking beyond the "label" of a diagnosis and recognizing the value of engaging in wellness activities and building meaningful connections. The ceremony highlights that individuals are not limited to being defined by their illness, and that it is possible to restore important life roles or create new roles. Ultimately, the awards help the clinic to be shaped into a welcoming, inclusive and safe space that encourages clients to support each other and be open about their recovery experiences.

Focusing on strengths and personal responsibility

The Archie Awards were created to acknowledge client strengths and have given practitioners the opportunity to "convey belief in people's capacity to reach their goals and have a life rich in possibility and meaning" (MHCC, 2015, p. 34). After the first awards took place in 2014, numerous clients expressed a wish to be nominated and hopefully win an award in the future. The awards opened up a dialogue about recovery and personal responsibility, as clients have discussed plans to attend groups and work toward personal goals. It has been evident over the years how the awards have fostered clients' belief in their ability to recover. With over 430 clients at the clinic and only seven award winners annually, it is a great honour to be recognized. Each year there are many nominations in each award category and the committee struggles to select a winner from the list of deserving candidates who all demonstrate that "people have the potential to recover, reclaim and transform their lives" (MHCC, 2015, p. 34).

Recognizing the value of family, friends and community

Family, friends and peers are recognized by mental health providers at the Downtown West Clinic as key supporters and promoters of client recovery. For this reason, they are always welcome to attend appointments with case managers and psychiatrists and to attend the two large clinic gatherings each year (a summer barbeque and a winter holiday party). The awards are yet another venue to which clients are encouraged to invite those close to them, offering them a chance to be part of a positive experience that fosters hope. The awards also provide the winning clients with the opportunity, when accepting their awards, to thank friends and family for the positive impact they have had on the client's life and recovery journey. This provides a chance to recognize the important role that clients' support networks play.

Opening remarks always welcome those close to clients, and the slide show allows them a glimpse into client groups and activities in which their loved ones participate at the clinic. The reception allows time for everyone to meet, interact and socialize. The feedback from family members who have attended the awards indicates their appreciation of being able to take part in the celebration of their loved one and meet practitioners and co-clients.

Concluding thoughts

As the committee plans for the upcoming Archie Awards and reads through the nominations, we are reminded of all the hard work our clients are putting into their recovery. We see clients who have shown great development related to their goals of employment or volunteer work; clients who are striving to further their education and learning; clients whose meditation, mindfulness, prayer or partnership with a higher connection has been a source of support in their recovery journeys; clients who have participated in community programs and provide ongoing support to their peers; and clients who have made gains in their wellness by attending programs in the areas of nutrition, smoking cessation and exercise. We are celebrating our clients by acknowledging their accomplishments, and we challenge you to do the same. There are a myriad of ways, both large and small, that we can recognize client successes. We encourage occupational therapists and other mental health professionals to identify and share with all of us the ways in which you can and do celebrate client successes in your own settings.

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Leisure participation: Collaborating toward recovery

Catherine White, Lara Fenton and Karen Gallant

Leisure: "an important pathway toward recovery, health promotion and life-quality enhancement" (Iwasaki, Coyle, & Shank, 2010, p. 485)

Introduction: Embracing recovery

Recovery is a strengths-based philosophy that involves building on existing individual, family, cultural and community assets to enable individuals with mental illnesses to live hopeful, self-determined and meaningful lives within environments of their own choosing. Canada is embracing the recovery paradigm, evident within our first mental health strategy, *Changing Directions, Changing Lives* (Mental Health Commission of Canada [MHCC], 2012). Implementing a recovery orientation in the mental health system requires attention to issues of meaningful engagement in community activities and social inclusion for those who face mental health challenges, if full citizenship is to be achieved (Davidson, Tondora, Lawless, O'Connell, & Rowe, 2009; Piat & Sabetti, 2012). Given their strong emphasis on enabling participation in meaningful activity, and their attention to overcoming both individual and environmental barriers, occupational therapists are well positioned to take a leadership role in advancing the strategy and supporting recovery.

Leisure: A neglected opportunity

While there are many ways of promoting mental health and supporting recovery (e.g., supported employment, subsidized housing), supporting engagement in leisure activities remains "largely neglected (and perhaps undervalued)" (Iwasaki et al., 2014, p. 159) as a key contributor to recovery and social inclusion. The purpose of this article is to highlight the relevance of leisure as a medium for recovery, to discuss barriers to leisure faced by people with mental health challenges and to provide an example of occupational therapy participation in an intersectoral collaboration using the newly-released *Guidelines for Recovery-Oriented Practice* (MHCC, 2015) to promote a better understanding of the role of leisure in recovery.

Leisure is one of three well-known domains commonly addressed in occupational therapy and is considered "a key domain of life (not just a trivial activity) that can help people gain valued meanings of life" (Shank, Iwasaki, Coyle, & Messina, 2015, p. 131). This is especially poignant given high rates of unemployment within the population of individuals living with mental illness. Research is emerging that supports the link between leisure and recovery, built through experiences of enjoyment, positive emotions, coping with stress, developing an identity outside of mental illness and establishing meaningful social and cultural connections (see, for example, Fenton et al., 2016; Iwasaki et al., 2014; Lloyd, King, McCarthy, & Scanlan, 2007; Shank et al., 2015).

Barriers: Facing obstacles to participation

The Canadian mental health strategy emphasizes the need to promote recovery in community-based settings, including those where leisure activities occur; however, it is within such settings that many individuals with mental health challenges face barriers (MHCC, 2012). People may feel vulnerable and unsafe in public spaces due to stigma, discrimination and social exclusion (McDevitt, Snyder, Miller, & Wilbur, 2006). Stigma, a risk factor for social exclusion (Clifton, Repper, Banks, & Remnant, 2013), can render people reluctant to step forward to pursue opportunities, as they may underestimate their capabilities or anticipate rejection (MHCC, 2015) resulting in "pre-emptive self-exclusion" (Fieldhouse, 2012, p. 422). These psychosocial barriers are not the same as the barriers experienced by people with physical disabilities, as they are "compounded by society's limited understanding of its role in the creation of them" (Fieldhouse, 2012, p. 422). This lack of awareness makes stigma and discrimination surrounding mental illnesses challenging to address and increases the participation barrier.

Guidelines for Recovery-Oriented Practice: A new tool

The *Guidelines for Recovery-Oriented Practice* (MHCC, 2015) highlight the importance of inclusive communities as the "space for recovery and active citizenship, where people find meaning according to their own customs, traditions, culture and upbringing" (p. 50). These guidelines direct service providers to help people to identify social, creative, spiritual and recreational needs, facilitate community connections and create opportunities that enable community and recreation participation. Additionally, to support social inclusion and

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recovery and promote occupational justice, there is a need to "identify the environmental and systems barriers that prevent people from engaging in occupations that promote health and quality of life" (Wolf, Ripat, Davis, Becker, & MacSwiggan, 2010, p. 15). Addressing these barriers requires linkages among community-based groups, supports and services. Further, recovery-oriented practice "encourages the formation of multisector partnerships . . . that support inclusion and address policies and practices that restrict opportunity" (MHCC, 2015, p. 42) for a more comprehensive approach.

Occupational therapists as partners for systems change: Recreation for mental health

As the *Profile of Practice of Occupational Therapists in Canada* (Canadian Association of Occupational Therapists, 2012) proposes, serving as a *collaborator*, working "effectively with key stakeholders to enable participation in occupations," and as a *change agent,* focusing on "positive change to improve programs, services, and society within health and other systems" (p. 3), are two key roles an occupational therapist can draw upon. Intersectoral members of our new collaborative community-based partnership drew on these roles to create opportunities to support recovery and developed an initiative called the Recreation for Mental Health project. Within this partnership, researchers from academic faculties of occupational therapy and recreation are collaborating with community-based mental health and recreation services, and service users, with the goal of promoting inclusive community environments that support leisure participation. The project has hosted three two-day symposia and facilitated regional working groups to promote awareness and cultivate local partnerships across Nova Scotia. It is currently engaging in locally relevant research and knowledge translation activities to support the creation of recovery-oriented practices.

Specific to transforming services and systems, the Recreation for Mental Health project has drawn on the MHCC guidelines, including four principles that support recovery-oriented practice at the systems level (2015, p. 78). The principles and our resultant actions include: 1) build recovery-promoting service partnerships (we have established linkages between recreation and mental health sectors with an advisory committee and through collaborative symposia), 2) acknowledge, value and learn from experiential knowledge (we actively include individuals with "first voice" perspectives at multiple levels of planning and decision-making and as speakers at each symposium), 3) implant a recovery vision and culture within and across organizations (we are learning about recovery from and with each other) and 4) develop a recovery-oriented workforce (which is a focus of our ongoing collaboration). The guidelines offer a useful lens for understanding the complex interactions that promote the uptake of recovery-oriented practice within the recreation and mental health sectors. Our intersectorial collaborations will need to ensure that recreation and health sectors are mutually informed, reflect current understandings of recovery-oriented care, acknowledge the benefits of leisure/recreation and increasingly incorporate "first voice" perspectives. As one of our "first voice" collaborators shared, partnering to "make social change or supports for people . . . that's what makes me feel alive and empowered and healthy and happy," acknowledging the value of "first voice" roles.

Conclusion: Creating pathways to recovery through leisure

Leisure is as "an important pathway toward recovery, health promotion and life-quality enhancement" (Iwasaki, Coyle, & Shank, 2010, p. 485), but remains undervalued and underutilized. As occupational therapists partner with intersectoral collaborators and people with "first voice" perspectives, we can draw on the *Guidelines for Recovery-Oriented Practice* and work together to "contradict negative stereotypes, balance inequities in social status, reduce social distancing, and reverse social disadvantage" (Krupa, 2008, p. 201) and thus support meaningful leisure participation for all.

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The Strengths Model: An innovative approach to community mental health case management

Danielle Hogan and Kathy Pennell

In the last three decades, there has been a tremendous shift in mental health care in Canada. Specifically, services have shifted from being delivered based on a medical model, in which care focused primarily on the impairment or disease, toward recovery-oriented models, in which care focuses on the individual in the context of his or her life, goals, dreams and aspirations. In Canada, person-centred services are now a target for system reform. In 2015, the Mental Health Commission of Canada outlined the *Guidelines for Recovery-Oriented Care*. In these guidelines, person-centred core principles, values, knowledge, skills and behaviours are emphasized as foundational aspects of recovery-oriented care. All six dimensions of the document, especially dimensions one and two ("creating a culture of language and hope" and "recovery is personal"), encourage the use of a strengths-based approach to care. The following paper provides an account of the adoption of such an approach in St. John's, Newfoundland. We provide an overview of the Strengths Model of Case Management (SMCM) and discuss how this team-based model of care has helped move recovery theory into clinical practice, with a particular emphasis on the occupational therapy perspective.

Background

In 2010, two community mental health programs within Eastern Health amalgamated to form case management (CM) services. In an effort to adopt an evidence-based, recovery-oriented and strengths-based approach, management led a small working group to explore best practices within community mental health CM teams. As a result, members discovered SMCM, a model that has been used in the United States since the mid-1980s (Fukui et al., 2012). The research gathered showed that SMCM is considered best practice and is linked to positive client outcomes, including increased employment, education and independent housing as well as decreased psychiatric hospitalizations (Fukui et al., 2012; Tse et al., 2016).

SMCM Team—St. John's

In 2011, staff of the St. John's CM program became the first Canadian team to train in SMCM and implement it into clinical practice. At present, team composition includes eight case managers of varying clinical backgrounds, including psychiatric licensed practical nursing, registered psychiatric nursing (RPN), occupational therapy and social work. The team is enriched by support staff including an occupational therapist clinical supervisor, an occupational therapist assistant, a therapeutic recreation specialist and an RPN clinical supervisor. Each case manager has a maximum caseload of 19 clients. Using SMCM tools and philosophy, they all provide supportive counseling, crisis prevention and management, symptom and illness management, skills teaching, education on medication and health, housing assistance, help establishing daily routines and client/family advocacy. Since putting this theoretical model into practice, we have demonstrated, through outcomes, that the strengths-based model effectively complements the recovery-oriented model.

SMCM

The SMCM was developed in response to traditional deficit-oriented approaches and designed to enhance recovery by taking a goal-oriented approach to working with clients (Brun & Rapp, 2001; Fukui et al., 2012). SMCM teams are "more concerned with achievement rather than with solving problems; with thriving more than just surviving; with dreaming and hoping rather than just coping; and with triumph instead of just trauma. For this to happen, people need goals, dreams and aspirations" (Rapp & Goscha, 2012, p. 39). Six core principles serve as the foundation for strengths-based practice: 1) people with psychiatric disabilities can recover, reclaim and transform their lives, 2) the focus is on an individual's strengths rather than deficits, 3) the community is viewed as an oasis of resources, 4) the client is the director of the helping process, 5) the worker-client relationship is primary and essential and 6) the primary setting for [case managers'] work is the community (Rapp & Gosha, 2012). Strengths include personal qualities and characteristics, talents and skills, environmental resources, and interests and aspirations. The goal of SMCM is to foster a relationship and an environment in which clients feel empowered to use knowledge learned, insight gained and their own natural supports and resources to make positive changes in their lives. In addition to being a philosophy of practice, SMCM is also a set of tools designed to enhance recovery (Fukui et al., 2012).

SMCM tools

The model provides a wide variety of tools that assist case managers with using SMCM in practice. The two primary

tools used include the strengths assessment (SA) and personal recovery plan (PRP), each of which has its own purpose, but they are used in conjunction to assist with goal exploration and attainment.

Strengths assessment

The SA is "a tool that helps the [case manager] stay purposeful in helping clients recover, reclaim and transform their lives. It is a tool, [which] when used well, offers a holistic view of the [client]" (Rapp & Goscha, 2012, p. 95). The SA focuses on seven life domains: home/daily living, assets—financial/insurance, employment/education/specialized knowledge, supportive relationships, heath/wellness, leisure/recreation and spirituality/culture. Much as an occupational therapist would apply the Person-Environment-Occupation model to optimize occupational performance (Townsend & Polatajko, 2013), case managers use the SA to inform their approach to helping clients with goal attainment. The tool explores the person by identifying the client's various past and present qualities, talents, skills and beliefs. The environment is explored with respect to past and present naturally occurring and formal resources in the person's life. Most importantly, occupation[1] is explored through identification and prioritization of the client's goals and aspirations, which become the focus of intervention. While the SA is a holistic portrait of the client, the PRP becomes the client's active to-do list.

Personal recovery plan

The PRP is a valuable tool for both case managers and clients, as it facilitates goal-oriented interaction in each session. The client identifies and prioritizes a self-identified goal and its importance. The case manager, collaboratively with the client, uses the PRP to break down the goal into smaller steps to facilitate goal attainment. Used each session, the PRP identifies the steps that client, case manager or both have agreed to undertake between sessions. Using the PRP is similar to engaging in the process of task analysis, essential to occupational therapy, in which a difficult task is broken into manageable parts to facilitate occupational performance.

The SA and PRP are powerful tools in SMCM, as when used regularly, they help both the client and case manager to remain client-centred and strengths-focused during each session. As in any area of practice, though particularly in mental health, it is not uncommon for symptoms, life stressors or crisis situations to sidetrack progress. SMCM has two built-in supervisory tools/processes, group supervision and field mentoring, to help case managers remain strengths-focused so they can help clients successfully continue their recovery journeys.

Group supervision

Group supervision is a weekly structured team brainstorming session that allows case managers to present client goals to gather creative suggestions and strategies for goal attainment. The various clinical backgrounds of the team members provide the case manager and the client the benefit of multiple unique perspectives. The distinct steps of the group supervision process allow for a respectful and supportive discussion of a particular client's goal, idea generation and the opportunity to gain knowledge of naturally occurring resources in the community. At subsequent client appointments, case managers discuss the group's suggestions and strategies as a means to decide on the next step toward achieving each discussed goal. In addition to brainstorming, case managers share client celebrations and achieved milestones. Through this affirming process, we hear successes such as "my client got a job last week," "my client starts school next month," "my client tried yoga for the first time" or "my client took the bus to bowling." Beyond client successes, team communication has changed from deficit-based (e.g., "client is a 41-year-old schizophrenic who wants a job") to strengths-focused language (e.g., "client is a 41-year-old female with previous work experience who wants to return to work"). We are learning through each other that goal- and recovery-oriented practice is embedded in SMCM. While the group supervision process creates opportunities for team collaboration, the field mentoring process allows for 1:1 support from a clinical supervisor for SMCM.

Field mentoring

Field mentoring is "a structured supervisory method used to help [case managers] develop and refine their practice skills . . . field mentoring involves the teaching of an agreed on skill, tool or method in an actual practice setting with a client" (Rapp & Goscha, 2012, p. 240). It is not intended to be punitive or micromanaging.

The supervisory components of SMCM help maintain a sense of accountability to the client and the model. The intention of supervision is to support case managers to use SMCM as effectively as possible to provide clients with a hope-inducing, strengths-focused and goal-oriented service. All four tools/processes are essential for the sustainability of the model and ultimately for our clients' successful journeys to recovery. An evaluation tool/process of particular importance is called fidelity.

Evaluation

Beyond staff experiences and client success stories, part of SMCM is the process of fidelity, an evaluation of the effectiveness of model implementation and adherence to model components (Fukui et al., 2012). Fidelity reviews involve clinical supervisor and case manager interviews, evaluation of the group supervision process, client focus groups and review of clinical notes, SAs and PRPs. A trained fidelity rater, other than a case manager, completes the fidelity reviews. In addition to recommendations from fidelity reports, feedback from the client focus groups is especially impactful. Clients have reported statements such as, "it makes a lot of difference when you have goals to work on," "she never thinks anything I want is stupid," "it helps improve my lifestyle," "it gives me something to focus on and I like going over [my PRP] frequently," "I like that it gets everything on paper and it gives

[1] Occupation is defined by occupational therapists as "groups of activities and tasks of everyday life" (Townsend & Polatakjo, 2013, p. 377).

me an idea of what my strengths are" and "when I look at [my PRP], it reminds me of things that are going well."

Outcomes

In St. John's, outcomes and fidelity ratings have improved on a consistent basis since implementation of SMCM. The fidelity scale consists of nine items in three core areas: structure, supervision and clinical/service, with each item rated on a 1-5 scale, with 5 signifying higher fidelity (Fukui et al., 2012). In addition to the fidelity items, demographics of clients are collected on a quarterly basis as a means to gather outcome information on housing, employment, education and psychiatric admissions. Table 1 shows the specific outcome areas and fidelity ratings within the SMCM program in St. John's, from data gathered from six months following implementation (October 2012) to the latest review in September 2015.

Table 1. *Client Outcome and Fidelity Ratings 2012-2015*

Outcome Area	6 Months Post Implementation: October 2012	September 2015
Employment	11%	20%
Hospitalizations	10%	9%
Education	8%	10%
Independent Living	75%	87%
Fidelity Item*		
Structure	3.3	4.5
1. Caseload Size	4.0	5.0
2. Community Contact	2.0	4.0
Supervision	3.0	5.0
3. Group Supervision	4.0	5.0
4. Supervisor	2.0	5.0
Clinical/Service	1.7	4.4
5. Strengths Assessment – quality	1.0	5.0
6. Strengths Assessment – Integration	1.0	4.0
7. Personal Recovery Plan	1.4	4.4
8. Naturally Occurring Resources	1.0	5.0
9. Hope Inducing Practice	4.0	4.0
Total Fidelity Rating	**2.4/5.0**	**4.6/5.0**

* Scores out of 5.0, where a high score indicates high fidelity

Conclusion

SMCM allows us to appreciate the whole person, his or her environment and his or her desired occupations in order to optimize occupational performance, supporting the foundation of the profession of occupational therapy. While this paper focuses on the occupational therapy perspective, SMCM is complementary to every profession that values a holistic, recovery-oriented approach. It not meant to replace clinical skills or ignore problems or illness, but rather remain hope-inducing and focused on utilizing individuals' strengths and their naturally occurring resources to achieve desired goals. One client captured the essence of SMCM when she stated, "We no longer just go for coffee and talk about the weather; we talk about me and what I want to do." From exploration to implementation to cutting-edge practice, we believe in the strengths of our clients and we believe that by working *collaboratively with* clients instead of working *for* clients, we instill hope and promote recovery.

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Translating innovative recovery-oriented psychosocial rehabilitation practices to low-resource regions to enhance community participation of people with serious mental illness

Regina Casey, Terry Krupa, Rosemary Lysaght, Ruth Ruhara, Victoria Mutiso, Sean Kidd, David Ndetei and Arlene MacDougall

Seventy-five percent of people who live with mental illness in low- and middle-income countries do not receive mental health services. This lack of access to treatment, along with social conditions such as poverty and stigma, negatively impacts community participation (Whiteford et al., 2013). In low-resource settings such as Kenya, this essentially renders people with serious mental illness (PWSMI) unemployable and relegated to the social margins.

Challenged by the funders of our project to find bold solutions to global health issues, our response was CREATE, a new paradigm for recovery that couples social business (SB) with focused and culturally informed psychosocial rehabilitation (PSR) practices and peer supports. This 18-month project is being conducted in Machakos, a city of approximately 150,000 people 60 kilometres southwest of Nairobi, Kenya.

This article begins with a brief overview of the key components of the initiative then focuses particularly on the evolution and implementation of a PSR toolkit. We conclude with reflections on the process and some lessons learned.

Key elements of CREATE

Social business

SBs are a form of social enterprise that have a primary goal of creating employment for members of marginalized groups. They are commercially viable businesses that produce and sell goods and services to the public. SBs can provide training and employment opportunities for PWSMI by creating workplaces that build on the capacities and strengths of workers. Like all businesses, to be successful they must be shaped by wisdom regarding the local context (e.g., market assessment, worker skills and interests, community needs and opportunities). Social businesses can offer a renewed sense of hope and community inclusion to people with mental illness and their loved ones by offering employment support and engaging participants as active agents in their own recovery. This strengths-based approach clearly resonates with values held by occupational therapists. In the context of CREATE, we consulted with PWSMI in Machakos, mental health service providers and local community business people to establish a print shop and lay the groundwork for the development of additional social businesses.

PSR toolkit

Knowledge of evidence based recovery-oriented PSR practices was translated for use in the local context in the form of a low-cost toolkit. Initially, it was developed for use by employees of the print shop SB to support their ongoing participation in the business, but also intended for broader dissemination and use in the local community. The PSR toolkit (described below) was designed based on the recovery paradigm. It was designed specifically to support PWSMI to learn about their health condition and engage them in developing health and wellness strategies as they become involved in opportunities for meaningful community and work participation.

Developing the toolkit

Our interdisciplinary team members remain committed to applying best practices for community development, such as building community capacity, creating real opportunities for participation, including participatory processes for information sharing and decision making, developing community partnerships, linking sectors and resources, and building sustainability for the project (Lauckner, 2011; Thibeault, 2013). Toward these ends, engaging local partners in toolkit development and sustainability included completing six focus groups as well as eight formal and numerous informal consultations with key informants. The consultations included over 50 unique individuals from multiple organizations, including local members of Users and Survivors of Psychiatry (USP) Kenya, staff and administrators of two Kenyan mental health hospitals, delegates from government bodies such as the Machakos Social Welfare and Empowerment Board, lawyers and teachers. In the spirit of emancipatory approaches, stakeholders were engaged early in the project, with the goal of building a sense of community and ownership in the actions and outcomes of the pilot intervention. People with lived experience, their family members, disability advocates and practitioners were consulted regarding their needs in relation to the content, style, language and dissemination of the toolkit. Stakeholders were also involved in pilot testing the delivery of the content. Consultation resulted in developing the toolkit in two sections (see the table below for details) and led to multiple refinements of the content, language and presentation of the material.

Table 1. ***Toolkit Contents***

Section 1 **Understanding Mental Illness**	**Section 2** **Building Skills for Recovery**
Resources to help individuals and their loved ones develop awareness and knowledge of illnesses, as well as to help individuals share personal experiences of illness	Resources to help people develop skills, strengths and supports in areas such as self-help, self-care adaptation and participation in valued roles/activities in chosen communities
Provides education on: Anxiety disorders, obsessive compulsive disorder, depression, bipolar disorder, post-traumatic stress disorder, schizophrenia, substance use/misuse and suicide, as well as development of personal awareness of symptom impact	**Provides sessions on:** Flourishing at work, building a support network, communicating effectively, developing wellness strategies, managing illness triggers, developing crisis plans and managing stigma
Approach: Psychoeducation, personal reflection, developing personal language regarding experience and needs	**Approach:** Based primarily on cognitive behavioural approaches within a group setting: identification of strengths and goals, education, roleplay, rehearsal, feedback and take-home practice

To build local capacity, interested people with lived experience and community health workers were trained in the use of the toolkit, with particular emphasis on how it can be used to support recovery. In addition, the training provided a platform for further engagement of stakeholders and helped identify and build the capacity of potential leaders. These initial training sessions also provided the opportunity to test out evaluation processes and measures. Feedback from this initial training was positive, with participants requesting further support and education. In general, trainees noted the training helped them gain facilitation skills as well as realize strengths, overcome stigma and become more reflective. In addition, changes to the toolkit were requested, such as simplification of language and increased information provision in advance of the training. One comment by a trainee made a particularly strong impact and furthered our understanding of the context in which we hoped to make change: "Marginalization … is deep within the place of work, … [in all] the counties, [in] the country and even in the constitution … [it] deprives mental patients of most of their human rights."

The next step in toolkit development involves a second round of training to develop facilitator expertise and engage stakeholders in formally evaluating the toolkit, beginning in June 2016 in a new urban location. If this is successful, we plan to scale the project up and to make the toolkit available to other low- and middle-income countries.

For additional information, please see: www.createkenya.com You can find a short video on the project at: https://www.youtube.com/watch?v=SNCj2wSSdd0

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Employment and education as targets for recovery in mental health care

Skye Barbic, Stephany Berinstein, Lyn Heinemann and Vivian Lau

In Canada, one of the central values of recovery is the belief that all people have the capacity to live a full and meaningful life. Increasingly, evidence suggests that individuals with mental illness view employment as central to recovery (Modini et al., 2016). Though an estimated 85-90% of adults with mental illness report that work is important to them (Barbic, Kidd, & McKenzie, 2016), paradoxically high rates of unemployment and underemployment exist (estimated ranges from 75-95%; Statistics Canada, 2015). With so many deeming employment to be crucial to their recovery, opportunity exists for occupational therapists in examining how employment support can be an integral service for any person with mental illness who wants it.

In this paper, we give examples of two programs with occupational therapist leadership that have taken unique approaches to delivering employment services. The common goal of the agencies is to achieve rates of success that are sustainable, meaningful and convincing to key stakeholders, to allow for ongoing funding of supportive employment programs as potential core interventions to be included in the spectrum of mental health services.

Gastown Vocational Services (GVS)

GVS is a specialized vocational service for individuals with mental health conditions living in Vancouver. GVS has been operating since 1991 and its staff comprises occupational therapists, job developers, peer support workers and a psychologist. GVS works with people in recovery to achieve their employment and education goals by offering a variety of employment services. GVS services are based on psychosocial rehabilitation (PSR) and recovery principles, focusing on each person's strengths and abilities and promoting wellness through individualized vocational plans.

GVS works with clients as part of a team to support individuals to gain the confidence, wellness, skills and experience needed to pursue their paid or unpaid employment or education goals. This is facilitated in part by a strong presence of occupational therapists in leadership positions at GVS and as employment coordinators. The role of occupational therapy extends beyond that of a traditional vocational service, as occupational therapy includes assessment and interventions that encompass all parts of a person in the context of their environment and health goals. At GVS, the occupational therapists work with clients, health-care teams and employers to coordinate employment and health plans, as well as to increase access to employment opportunities in the community through job development and advocacy.

Inner City Youth Program (ICY)

Young adults aged 15-24 are typically completing school and/or skills training, laying the foundation for a stable future. ICY, a health service for marginalized youth living in Vancouver, has worked to identify gaps in how its clients develop job skills and enter employment or continuing education. This service now employs an occupational therapist as a navigator, or broker, to support clients to achieve employment and educational pursuits.

For youth who have employment goals, the role of the occupational therapist is to work with clients to develop dynamic action plans that coordinate health, employment and wellness goals, as well as involve employers and health teams to optimize the long-term employment potential of clients. For youth attending school, the occupational therapist's role is to contribute to individualized educational plans to ensure adequate support is in place and there is continuity between school and health aspirations.

ICY has established partnerships with employers and community agencies such as the YMCA to design programs that are accessible and tailored to marginalized youth. The team now includes peer support workers and has partnered with the University of British Columbia to monitor the efficacy, adaptability and cost effectiveness of its services. This allows for objective program evaluation and the immediate integration of the youth perspective in program development and planning of services.

Concluding thoughts

Access to employment and education is essential for the well-being of all people with mental illness and for society as a whole. Opportunity exists now for occupational therapists to lead initiatives to examine how supported employment and education services can be delivered through a recovery and PSR lens and in the most robust, evidence-based way possible.

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