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TEACH: A Framework for Recovery-Oriented Education and Training

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Abstract
Recovery-oriented services for people with mental illness are best practices, yet related education and training is not well developed. This article highlights an approach – TEACH (Theory, Evidence, Action in Care for Health) – to facilitate recovery-oriented education and training. Research about TEACH and other recovery-oriented education and training approaches is needed.

Introduction:
Providing recovery-oriented services assumes that providers are educated and trained appropriately. Such education and training in relation to recovery and related services requires teachers to be recovery-oriented in the education and training they provide to learners. There is no generally accepted framework to guide such education and training. In this paper, I report an education and training framework – TEACH (Theory, Evidence, Action in Care for Health) – that I have developed, and its application to recovery-oriented education and training.

Sound education and training uses theory, empirical evidence and practice (action) iteratively and contextually. Thus, all three TEACH components should be used by recovery-oriented teachers. In relation to theory, recovery-oriented teachers can use theories of psychiatric rehabilitation (among other theories), such as Anthony et al's formulation of environments of choice (Anthony, Cohen, Farkas, & Gagne, 2002). In relation to evidence, recovery-oriented teachers can use evidence such as facts about recovery-oriented systems and services (Nelson, Kloos, & Ornelas, 2014). In relation to action, recovery-oriented teachers can use practice such as exercises for person-centered care planning (Tondora, Miller, Slade, & Davidson, 2014). This is about the content – the "what" – of education. What about the process – the "how" – of education?

As noted above, sound education and training is iterative. In relation to TEACH, this means that theory, evidence and action inform each other and are taught in stages and in cycles (or perhaps using a better visual analogy, in spirals), so that after basic theory, evidence and action are addressed, often focusing on awareness

and knowledge (Knowles, Holton and Swanson 2011), more advanced level theory, evidence and action are addressed, often focusing on skills and attitudes (Ibid). The order of theory, evidence and action may change, although starting with theory, proceeding to evidence, and continuing with action may make most sense in many situations. For example, learning about theoretical aspects of recovery (Rudnick, 2012) and about evidence related to person-centered care for people with serious mental illness (Rudnick & Roe, 2011) is conducive to and hence may best precede learning person-centered care planning (Tondora, Miller, Slade, & Davidson, 2014). That being said, learning style – intellectual, experiential or other – may determine this order. And teaching style – which is often ignored – may also contribute to this determination; for an overview of some teaching styles and a measure to assess them, see the teaching perspectives inventory (https://facultycommons.macewan.ca/wp-content/uploads/TPI-online-resource.pdf), which addresses five teaching styles that each teacher exhibits to a smaller or larger extent – 1. transmission, which is knowledge focused; 2. apprenticeship, which is skills focused; 3. developmental, which is reasoning focused; 4. nurturing, which is support focused; and 5. social reform, which is values focused.

Sound education and training is also contextual. In relation to TEACH, that means that relevance or pertinence of theory, evidence and action is imperative. For example, Anthony and colleagues use theory from physical rehabilitation to teach psychiatric rehabilitation (Anthony, Cohen, Farkas, & Gagne, 2002). And although the conventional biomedical model of care is foreign to a recovery-oriented approach, clinical communication practice that was developed for medical education purposes can be useful in recovery-oriented education and training, as in the teaching of structured empathic communication (Buckman, 2010).

An illustration of TEACH based on some of my psychiatric rehabilitation education and training innovation (Rudnick & Eastwood, 2013) may be relevant and helpful. For example, when teaching psychiatric rehabilitation to obtain and maintain success and satisfaction in social environments of choice, basic theory can be related to social behavior and to stigma and advanced theory can be related to social cognition and to structural inequalities in society; basic evidence can be related to effects of social skills training and to stigma reduction and advanced evidence can be related to effects of social cognition remediation and to advocacy; and basic practice can be related to social skills training and to stigma reduction while advanced practice can be related to social cognition remediation training and to advocacy training. Applying TEACH facilitates staging and otherwise individualizing such education and training, so that teachers can help learners customize such education and training, using a fairly structured and reasoned approach. Thus, an intellectually oriented learner who has no knowledge of this area of psychiatric rehabilitation would likely need to start with learning about social behavior and stigma, and then proceed to learn about and practice social skills training and stigma reduction. An experientially oriented learner who has already learned social skills training would likely benefit from social cognition remediation training and advocacy training.

In summary, TEACH is a framework that is applicable to recovery-oriented education and training. Research about, as well as further development and attempted implementation of, TEACH and other frameworks for recovery-oriented education and training are needed.

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