



15. Recovery Colleges 10 Years On

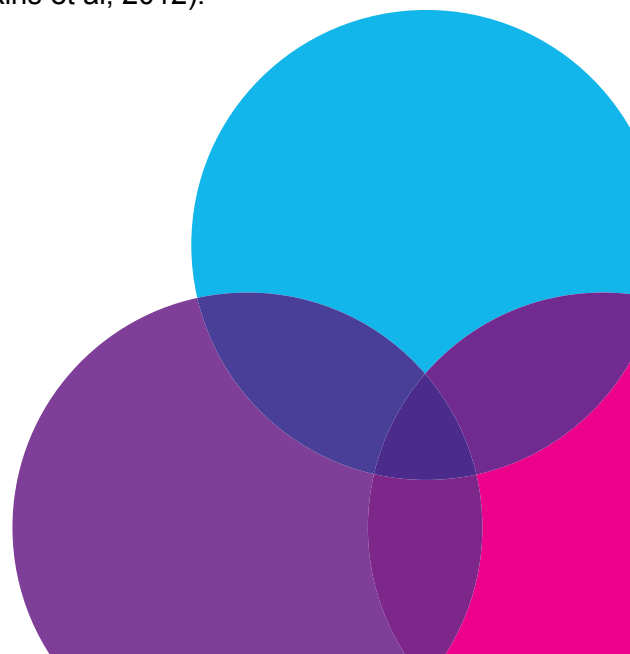
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Rarely has an idea in the mental health arena been taken up so widely or so quickly as that of a 'Recovery College'. The idea of a Recovery College was first mooted, and initial specifications drafted, in 2007/2008. The first UK pilot Recovery College was established in the London Boroughs of Merton and Sutton in 2009 (Rinaldi and Wybourn, 2011) leading to the establishment of the South West London Recovery College serving 5 London Boroughs in 2010. By 2017 over 75 Recovery Colleges have been established in the UK and in other parts of the world including Australia, Canada, Hong Kong, Japan, the Republic of Ireland, Scandinavia and Western Europe. An international Community of Practice has been established and in 2017, the European Union Regional Development Fund invested 7.6 million Euros to build on existing initiatives and create a 'Cross-Border Recovery College Network' serving 8000 people facing mental health challenges in Northern Ireland and the border counties of the Republic of Ireland. Across Europe, Erasmus is funding the development of Empowerment Colleges,

based on the Recovery College model, in Germany, Holland, Italy, Poland and Bulgaria.

Recovery Colleges form a core part of the development of more recovery-focused mental health services that enable people to grow within and beyond what has happened to them; discover a new sense of self, meaning and purpose in life; explore their possibilities and rebuild a satisfying and contributing life (Deegan, 1988; Anthony, 1993; Repper and Perkins, 2003, 2012; Perkins et al, 2012).



If mental health services are to assist people in their journey of recovery a major change in culture and practice is required in the form of a redefinition in the purpose of services – from reducing symptoms to rebuilding lives – alongside a transformation of the relationship between mental health services, the people they serve and their communities (Perkins, 2012; Repper and Perkins, 2012). Recovery Colleges embody this transformation and can be central to driving broader organisational change. Within the College both people who use services and those who provide them experience a different sort of relationship that challenges unhelpful practice, attitudes, behaviour and prejudice by modelling a different conversation and understanding.

All Recovery Colleges started small, with maybe eight or nine courses, but most have grown rapidly to offer dozens of different courses in multiple locations and serve thousands of students each year. Typically, a College will have a small team of peer and mental health practitioners employed directly by the College, supplemented by a larger group of sessional peer trainers and sessional mental health practitioner trainers drawn from among staff within mental health services and from community agencies. Some also offer opportunities for unpaid, volunteer trainers¹ which can provide people with experience prior to applying for paid positions.

During its pilot phase in 2012, the Central and North West London (CNWL) Recovery & Wellbeing College had 87 students enrol and 224 attendances. Individual students comprised of 68 people who use services, 2 supporters and 17 staff. 13 courses were co-delivered across two of the Trust's London boroughs.

Activity has increased year on year, in 2015/2016, 1067 individual students enrolled, with 3202 attendances across the College. These comprised of 622 people using services, 56 supporters and 389 staff. 91 courses were co-delivered across the whole of the Trust. Between 2012 and 2016, 4,161 students have registered, with a total of 12,764 attendances. 64% of students are people who use CNWL services, 8% their supporters and 28% are CNWL staff.

In 2015/2016 the core team consisted of 14 management, administration and peer and practitioner trainers (11.5 whole time equivalents), 17 sessional peer trainers, 3 volunteers and 38 sessional practitioner trainers (drawn from existing CNWL services). The increase in the number of courses being co-developed and co-delivered would not have been possible to achieve without the support of sessional peer trainers and sessional practitioner trainers who, although employed elsewhere across CNWL, co-develop and co deliver courses for the College.

The College operates on a hub and spoke model. The College hub is based at the Trust's Headquarters. This model ensures that people using services, their supporters and staff can access a number of courses locally or can choose to travel to other boroughs. The extent of the range of spoke courses available is dependent upon identified need and the local capacity of staff to co-deliver the workshops/courses.

In addition to the established spokes, the College has also developed partnerships with many different organisations including local universities and Colleges; Job Centre Plus; the Reader Organisation, local GP practices and carer groups. Internal partnership within CNWL include Employment Services, Addictions and Offender Care Services (including Winchester and High Down Prisons), CNWL Arts in Health, inpatient and rehabilitation units, Art Psychotherapies, Eating Disorders and Learning Disability services.

www.cnwl.nhs.uk/recoveryCollege

¹ Although volunteers report valuing such opportunities concerns have been raised by some about getting peer expertise 'on the cheap'. If peers are unpaid and practitioners are paid for their work then questions may be raised about the relative value accorded professional and lived experience.



The curriculum and courses vary from brief, one-hour, introductory sessions to a day per week for a term (10 weeks) with probably the majority being 2-3 hours per week over 4-6 weeks. They are locally co-produced and therefore curricula vary from College to College, however the range of courses and workshops offered typically covers a number of areas:

- understanding different mental health issues and treatment options (for example, understanding a diagnosis of depression and understanding psychological therapies).
- rebuilding life with mental health challenges (including introduction to recovery, ‘telling your story’, mindfulness, spirituality, improving sleep, living with depression, the development of self-management and personal recovery plans).
- developing life skills and confidence to either rebuild life outside services (for example, return to work or study, getting e-connected and looking after your personal safety) or get the most out of services (for example, getting the most out of your care review, negotiating with your psychiatrist and understanding the Mental Health Act).

- capacity building and developing the peer workforce (including ‘train the trainer’ courses and those designed to enable peers to participate in staff selection or sit on committees).
- helping people to provide support for family members and friends who experience mental health challenges.

Initially, Recovery Colleges focused on mental health challenges, but have more recently extended to people with learning disabilities, long-term health physical conditions and dementia, forensic services, long-term health conditions, dementia and homeless people and offer courses in primary care settings.

Based on the experience of the first three UK Recovery Colleges in South West London, Central and North West London and Nottingham, ImROC produced a briefing paper in 2012 (Perkins et al, 2012) outlining the principles of a Recovery College. The purpose of the current briefing paper is to build on this and explore the experience and outcomes of Recovery Colleges over the last ten years.

DEFINING FEATURES: WHAT IS A RECOVERY COLLEGE?

An understanding of the importance of recovery education predates the Recovery College (see Perkins and Repper, 2017). For example, in the UK the ‘Expert Patient Programme’, to help people to manage a range of long term health conditions, began in 1999 (see Department of Health 1999, 2001, 2006). However, while peers with lived experience co-facilitate these courses, unlike a Recovery College, the content is largely prescribed by professionals and is largely prescriptive and manualised. They focus on symptom management rather than the broader issues involved in rebuilding a life and only those with long term health conditions can attend.

In the USA, the Boston Centre for Psychiatric Rehabilitation offers a recovery education programme that grew out of rehabilitation skills training approaches: *“an adult education program that offers students the opportunity to choose a range of wellness courses that support their rehabilitation and recovery efforts”*. Developed from the Boston model, the Recovery Education Centre in Phoenix, Arizona, provides *“trained peer facilitators [to] help individuals develop skills and tools that can lead to success in all aspects of wellness and daily living.”* However, these US initiatives differ markedly from the Recovery Colleges developed in the UK. For example: they are deliberately separate from clinical services and are not designed to address clinical issues of diagnosis and treatment.



They offer a discreet number of courses that are typically manualised and run over several weeks, rather than the wide range of learning opportunities ranging from one off workshops to fully accredited courses found in Recovery Colleges. They offer recovery focused education but do not bring together the expertise of lived experience and professional expertise in a process of co-production or co-learning. They are based on a largely didactic model of learning rather than a more democratic learning environment in which the expertise of all is valued and shared.

While learning from these recovery education initiatives, Recovery Colleges represent a departure in terms of models and approach. They offer a comprehensive range of courses based on the wishes and needs of those who use them and form a core part of mental health services. They embody a shift from a focus on therapy to education and explicitly bring together the expertise of lived experience and professional expertise in an inclusive learning environment in which people can explore their possibilities. Perkins et al (2012) outlined 8 principles of a Recovery College that have been elaborated with subsequent experience:

1. **They are founded on co-production:** they bring together the expertise of lived experience and professional expertise in all aspects of their design and operation from initial planning through decisions about operation and curriculum design through to the development of courses and workshops, delivery of training and quality assurance. Co-production is not a 'one off' exercise but an iterative process of review and re-creation that involves not only the tutors but also those attending the courses. Typically, a College will have a small team of peer and mental health practitioner trainers employed directly by the College, supplemented by a larger group of sessional peer trainers and sessional mental health practitioner trainers drawn from among staff within mental health services and from community agencies.
2. **They reflect recovery principles in all aspects of their culture and aspiration.** This includes not only the content of courses and workshops, but also a physical environment that conveys messages of hope, possibility and empowerment and recovery language that highlights strengths and possibilities rather than deficits, problems and shortcomings
3. **They operate on College principles.** Students are not 'referred to' the Recovery College or assessed for their 'suitability' to attend. Instead, they select the courses from a prospectus. There is no selection based on diagnosis or clinical condition and they do not offer treatment, care co-ordination or perform risk assessments. If the person is considered safe to leave a ward by the clinical team, then they can attend the Recovery College. If they are not, then a member of staff may accompany them as a fellow student or courses are organised within the ward
4. **They are for everyone.** This includes people who use mental health services, people who are close to them, staff from mental health and related agencies and people from local communities who are outside the mental health system. The ethos is that everyone learns together and from each other.
5. **There is a Personal Tutor (or equivalent)** who can offer information, help people develop a learning plan based on their wishes and aspirations and select courses in line with these.
6. **There is a physical base.** A building with classrooms and a library so people can do their own research. Most Recovery Colleges adopt a 'hub and spoke' approach with a central base and satellite courses in different locations. Often these involve partnerships between the Recovery College and other agencies like Universities, Community Colleges or, as in Northern Ireland, the local Library Service. A physical base offers a focus for the College and enables people to come and see what is available before taking the plunge of registering for a course.



The Recovery Library is not intended to replace local libraries, but instead to contain recovery materials including, for example, self-help materials, personal stories, DVDs, information about different sorts of treatment and therapy and, most importantly, internet access to increase the possibilities for self-conducted research.

7. ***They are not a substitute for the specialist assessment, treatment and therapy offered by clinical teams.*** However, they may replace and extend a variety of less specific groups, individual work and psycho-education. By blending lived and professional experience they can increase people's understanding of their problems, how they can manage these and how they can make informed choices about the support and treatment they want.
8. ***They are not a substitute for mainstream Colleges.*** However, they may run 'return to study' courses to enable people to access mainstream education and training opportunities, if this is their wish, and enable people to gain the confidence and skills to manage their mental health challenges in other educational settings.

The first four of these principles would appear to be the critical dimensions of a Recovery College. King (2015) surveyed 23 staff from ten Colleges and asked them to rank the original ImROC Defining Features of a Recovery College in order of importance. In order of importance the first four were that it ***reflects recovery principles***, is ***founded on co-production***, is ***for everyone*** and it ***operates on College principles***. In an in-depth review of Nottingham Recovery College (McGregor et al, 2014) these principles have been elaborated into 6 'critical dimensions' of success

1. **Educational.** Based on educational principles and a co-produced, recovery-focused curriculum with each student having an individual learning plan based on their wishes and aspirations. Students choose the courses they are interested in attending - *not* referral-based.

2. **Collaborative.** Based on co-production in all facets of their operation, curriculum and course development, co-facilitation and co-learning that brings together lived, life, professional and subject expertise.
3. **Strengths-based and person centred.** The strengths, skills, qualities and possibilities for staff and students are identified, built upon and rewarded. For both students and staff, achievements, strengths, skills and qualities are identified, built upon and rewarded.
4. **Progressive.** Actively support students to move on in their lives, to achieve their own identified goals and explore possibilities outside services.
5. **Community facing.** There is active engagement with community organisations and mainstream education facilities in the local community and an emphasis on partnership working
6. **Inclusive.** Recovery Colleges welcome students of all types, cultures, abilities and educational achievement. There are no diagnostic requirements or exclusions and no formal risk assessment. They also welcome mental health practitioners, other mental health staff, relatives, friends, carers and people in the local community and are free to all. Everyone learns together and from each other.

Three of the original principles of a Recovery College (Perkins et al, 2012) not explicitly described in this list can be subsumed within these 'critical dimensions' of success:

- ***The original principle of there being a 'personal tutor'*** (Perkins et al, 2012) ***is subsumed within the educational principles***: it is a personal tutor who assists people to develop their individual learning plan.



- **The original principal that Recovery Colleges are not a substitute for formal individual therapy can probably be subsumed within the ‘educational’ dimension.** This is important because some have criticised them for depriving people of important, evidence based therapies and interventions (see Recovery in the Bin, 2017). As indicated in the original principles (Perkins et al 2012) they may replace some less specialised ‘individual work’ and support for self-management, by blending the expertise of professionals with that of lived experience and enabling people to learn from each other.
- **The original principle that that Recovery Colleges are not a substitute for mainstream Colleges can probably be subsumed within the ‘community facing’ dimension.** It is critical that Recovery Colleges act as a conduit towards mainstream learning and training opportunities in the community rather than a segregated alternative to these. However, it is equally important that they act as a conduit to, rather than a substitute for, other community opportunities as well.

The issue of whether a physical base is required may be more contentious and no research has been conducted looking at the importance of this. Many Colleges have found that a central base offers a critical core – a tangible representation of commitment to the model - that provides an identity and offers the opportunity for trainers and students to meet.

While most Recovery Colleges operate satellite courses in different locations, they usually find it important to have a central ‘hub’ from which the ‘spokes’ emanate. A base also allows students from different courses to meet each other and share experiences. It is a common occurrence to see students who have met at the College developing friendships and engaging in activities together outside the College.

In any learning environment, it is important that students have the opportunity to do their own research and a base offers the opportunity to provide this in the form of a Recovery Library with access to computers, reading materials, DVDs... Such a library

can be an important means of driving forward a recovery agenda across mental health services more broadly. It provides a resource that can be used by others within mental health services: both people with mental health challenges and mental health workers can access important recovery materials and mental health practitioners can direct the people they support to the library where they can find these. In one Trust, a visit to the Recovery College and its library formed part of the induction for junior doctors and, having seen what was available, they regularly sign-posted clients to the resource.

Research conducted into what students and trainers value about Recovery Colleges, while not specifically directed towards defining their key characteristics, can shed light on the principles or critical dimensions of success.

- Meddings et al. (2014) drew on interviews with students and course feedback forms to explore the experience of a Recovery College and what students with mental health challenges valued.
 - **Learning from other students:** ‘we are all in the same boat’; ‘realise you’re not the only one’.
 - **Co-production and the valuing of lived experience:** ‘it was the equality, learning from peer trainers’ lived experience and professionals that helped’.
 - **A safe supportive environment and the personal qualities of staff:** ‘empathy, warmth and a welcome’.
 - **Learning new knowledge:** ‘it was helpful to learn techniques that help me manage my anxiety’, ‘learning something new gave me confidence’.
 - **Social opportunities:** ‘I have met people I will continue to meet up with’.
 - **Structure:** ‘I learned that I need to have a structure to the week’.
 - **Choice and control:** ‘choice is empowering – you choose what course from a prospectus, instead of professionals assessing and referring’.



- **Progression:** 'I feel more prepared to tackle voluntary work'. However, some students noted that this could have been improved.
- Zabel et al. (2016) carried out focus groups with a range of students: those who had experience of mental health challenges, family members or carers and health professionals. They found three positive themes.
 - **Ethos:** inclusive, values of staff, choice and open access.
 - **Personal and organisational impact:** practical skills learned (for all groups), progression into work or improved practice and motivation.
 - **Value of co-production:** personal narratives of lived experience facilitator, co-learning in a balanced group of carers, staff and people with mental health problems, learning from each other, breaking down barriers.
- In Australia, Hall et al. (2016) report the aspects of Recovery College which contributed to positive outcomes:
 - **Education,** gaining new knowledge and perspectives.
 - **A recovery oriented service model** that felt safe and where people were seen as people.
 - **An enabling environment with a community of students and staff where people learned from each others' similar and different experiences** and gained a sense of hope and empowerment.
- Sommer et al (2017) in Sydney, Australia, identified four key positive themes in a focus group study:
 - The **sense of connection** with others which decreased their sense of social isolation.
 - The **sense of hope and inspiration** that was instilled through sharing and being with others who were on a recovery journey.
 - The **importance of the lived experience** in creating a safe space for the sharing of stories and the impact of **co-learning** that occurs with consumers and clinical staff sitting side-by side as students, as equals, in the Recovery College.
 - The potential for **changing attitudes and systems** through a renewed and deepened understanding of the meaning of recovery for both consumers and staff.
- Perkins et al. (2017) cite three themes as being the reason for the staff students' positive experiences: **co-learning; co-production and co-facilitation**, and the **content** of the courses. Similarly, King (2015) found that participants rated **co-production as one of the most important defining features of Recovery College, second only to recovery principles.**
- An evaluation of the Central and North West London Recovery and Well-being College (2015) emphasised the value placed on **co-learning:** when asked if learning alongside people who use services had been a positive experience, 100% of carers and staff said 'yes'.
- Finally, Shepherd (2015) argues that it is more than education and involves **a changed power relationship and the reduction of stigma.** He discusses how self-stigma is reduced through information replacing ignorance with hope; opening up what might be possible; rediscovering a sense of control or empowerment. Co-production and getting involved and helping others reduces prejudice. This leads to a re-evaluation of self and overcoming prejudice towards oneself. He suggests this requires a safe environment where people can support and learn from each other and then feel less isolated or alone. This then facilitates further progression and further challenges to self-stigma. Recovery Colleges may also reduce organisational stigma and prejudice.

In summary, such studies emphasise a number of key features of Recovery Colleges: **co-production, co-facilitation and co-learning** (all of which change power relationships and break down ‘them’ and ‘us’ barriers) alongside **a progressive, recovery-focus, an educational approach and the opportunity for peer support**, and the important role that Recovery Colleges have in the **transformation of attitudes and systems more broadly across the mental health system**.

Sussex Recovery College is a partnership between Sussex Partnership NHS Foundation Trust and Southdown. Over 20 other partner organisations work with the College to provide courses or other input, for example MindOUT, Recovery Partners, Capital, Rethink, Richmond Fellowship and Sussex Wildlife Trust.

It began as two pilots with Mind and Sussex Partnership in Brighton and Hastings. The first courses ran in Spring 2013. During the pilot there were 44 courses and 236 students. Now the Recovery College operates across campuses in East and West Sussex and Brighton and Hove. In a typical term, there are 90 courses including some single workshops. Each term 800 students register with the College, two thirds of whom are new and one third returning. 75% students who start courses go on to complete them with at least 70% attendance. The majority of students are people with mental health challenges: 60% use secondary mental health services and 18% primary care; 10% are relatives or carers and 10-16% staff. Some of the most popular courses include understanding psychosis, coping with anxiety, happiness, improving your sleep, and using the arts to aid recovery.

The day to day running of the campuses is local with separate administration and two managers (one for Brighton and one across east and West Sussex). Quality, research and audit is organised on a pan-Sussex Recovery College basis. The College is overseen by an academic board chaired by the NHS Trust Director of Education and Training and comprising senior peer trainers and student reps from each campus, managers, administrators, clinicians and researchers, and representatives from a range of partner organisations.

The College employs three senior peer trainers, 49 sessional peer trainers and 70 sessional subject area expertise trainers such as clinicians. There are student unions in each area and currently 7 student reps who represent students at campus steering groups and / or at the quality, research and audit meetings. Buddies who support students to get to and attend classes are provided by peer led organisation Capital and by Southdown volunteer buddies working in the College. There are four other volunteers – two admin, one peer trainer and one psychology graduate intern.

There is also a pilot discovery College working with children and adolescents.

www.sussexrecoveryCollege.org.uk



THE EFFECT OF RECOVERY COLLEGES: THE RESEARCH EVIDENCE

To date there are no formal controlled trials exploring the effectiveness of Recovery Colleges, and given the iterative nature of the core co-production process on which they are founded, there may be significant problems in adopting such a methodology. However, there is a substantial body of evidence from two sources.

First, although Recovery Colleges are more than the sum of their parts, there is a separate evidence base for the components that they include and build on (see Watson, 2013 for a summary). For example, there is a considerable body of evidence demonstrating the effectiveness of supported self-management education (see Rinaldi, 2002; Foster et al, 2007; Cook et al, 2011; National Voices, 2014), indeed the National Institute for Health and Care Excellence (2011) states that support for self-management is one of the quality standards that adults can expect from mental health services. Similarly, there is now a wealth of evidence for the value of peer support (see Castelein et al, 2008; Repper and Carter, 2011; Davidson et al, 2012; Repper, 2013).

Second, there is a strong and consistent body of evidence from an increasing number of uncontrolled studies of the positive impact of Recovery Colleges in several areas.

1. The effective of Recovery Colleges on people facing mental health challenges who attend them

a) **Quality of recovery-supporting care.**

Recovery Colleges are popular and students are highly satisfied. For example, Rennison et al. (2014) and Meddings et al. (2014) in UK and Gill (2014) in Australia report that over 95% students said that the course they completed was 'Good' or 'Excellent' and that they would recommend it to others. Bristow (2015) found that 97% of students would recommend their course to others. An analysis of Sussex Recovery College termly reports 2014-16 shows that the positive feedback continued beyond the period of formal evaluation reported in Meddings et al (2014). Over 95% of the 3,611 students providing feedback said

they would recommend the course they did to others. Again, Hall *et. al.* (2016) report high levels of satisfaction and a recovery oriented environment using the DREEM. Recovery Colleges also have quite high attendance rates, generally around 60-70%, consistent with mainstream adult education (see, for example, Rennison, 2014, Bristow 2015, Meddings *et al.* 2015).

b) **Achievement of personal recovery goals.** Recovery College students make progress towards their own personal recovery goals (Rinaldi and Wybourn, 2011; Meddings *et al.*, 2015; Burhouse *et al.* 2015; Sommer, 2017).



- c) **Subjective measures of personal recovery.** Two Colleges have demonstrated significant improvements in personal recovery using the Process of Recovery Questionnaire which maps onto the CHIME framework of connectedness, hope, optimism, identity, meaning and purpose and empowerment (Nurser, 2016; Meddings et al., 2015). Students report feeling significantly less self-stigma after attending Recovery College (Nurser, 2016). They also show progress as measured by the CHOICE (Meddings et al., 2015).
- A number of other Colleges report people say they feel more hopeful about the future (e.g. Rinaldi and Wybourn, 2011; Rennison et al., 2014; Solent, 2014; Sommer et al, 2017) and one College suggests increases on the Herth Hope index however the numbers are small and they do not report significance testing (Stone et al. 2014). Students report increased sense of control, agency and self-determination (Solent, 2014; Stone 2014; Sommer et al, 2017). Students also report improvements in self-esteem and self-confidence (Central and North West London, 2015). Burhouse et al, (2015) reports qualitative data regarding students' personal transformation with increased hope, sense of empowerment, sense of belonging and knowledge and decreased shame about their illness.
- d) **Quality of life and wellbeing.** Two Colleges have shown that quality of life and wellbeing was significantly improved after attending Recovery Colleges as measured by both Warwick Edinburgh Wellbeing Scale (WEMWBS) and Manchester Short Assessment of Quality of Life (MANSA) (Meddings et al., 2015; North Essex Research Network, 2014). Sussex Recovery College termly reports have shown this to be replicated with N=456 students.
- e) **Achievement of socially valued goals.** Rinaldi and Wybourn (2011) reported that almost 70% of students surveyed 18 months after first attending the College, had become mainstream students, gained employment or started volunteering. Rennison *et al.* (2014) and Hall *et al.* (2016), using the social inclusion web, found students reported significant increases in contact with education, employment and volunteering, the arts, and social interactions with family and neighbourhood. Meddings *et al.* (2015) found increases in social networks and the number of people students felt able to talk to about mental health and recovery, but not increases in work or education.
- f) **Knowledge and Skills.** Over 80% of students feel they have greater knowledge, skills and understanding after attending a Recovery College (Burhouse *et al.*, 2015; Bristow, 2015; Meddings *et al.* 2014b; Sommer, 2017) and over 70% felt confident in using these skills (Meddings et al 2014b). Unpublished Sussex Recovery College termly reports all show significant improvements in students' progress with course learning outcomes. Students also report developing their own self-management plans for how to stay or become well (Rinaldi and Wybourn, 2011).
- g) **Service use and cost-effectiveness.** There is evidence that attendance at Recovery Colleges is associated with reduced hospital and community service use (Rinaldi and Wybourn, 2011; Mid-Essex Recovery College, 2014; Barton and Williams, 2015; Bourne et al. 2017 in press). Bourne et al. (forthcoming) in a controlled before and after design study (N=463) report that students who attended the Recovery College showed significant reductions in occupied hospital bed days, admissions, admissions under section and community contacts in the 18



months post compared with 18 months before registering. Reductions in service use were greater for those who completed a course than those who registered but did not complete. The population who did not attend the Recovery College did not show such reductions. They estimate non-cashable cost savings of £1200 per registered student which is similar to £1240 estimated by Mid Essex Recovery College (2014) and greater than the potential cost savings of approximately £800 per student per year for those attending more than 70% of their chosen courses estimated by Rinaldi and Wybourn (2011).

Barton and Williams (2015) performed a detailed study of Return on Investment of the Barnsley Recovery College, South West Yorkshire Partnership Trust. They focused only on staff costs and compared the period of 6 months after attending the College with the 6 months prior to attending the College for a random sample of 40 people. The cost of the support they received from Trust and Local Authority staff in the 6 months prior to attending the Recovery College was £11,200 and for the 6 months after attendance was £3,757: a 66% reduction in cost of £7,447 which equates to £186 per person over 6 months (£372 per year). Although a small number of people received increased support, 21 people who did not require any ongoing support after attending the College.

A letter from a student at the Central and North West London Recovery and Wellbeing College

To everyone at the Recovery College,

I wanted to write to say thank you for all the work you do. I've been doing courses with you for just over a year now and have benefited so much from them.

I was very scared and sceptical the first time I attended a course, but it turned out to be one of the best decisions I've made...I really benefited from hearing others share their experience, particularly the peer trainer. And this is something I've continued to appreciate on all the courses I've done. The College creates such an accepting and encouraging atmosphere and I've really found my confidence has grown so I now feel able to share my own thoughts and experiences- something which seemed impossible at first. I've learnt a lot too and have particularly gained from developing a Health & Wellbeing plan.

You are doing such a great job and I just wanted to write and tell you, and thank you.

To date there have been no studies specifically exploring the impact of Recovery Colleges on the relatives, friends and carers of people experiencing mental health challenges, however, informal feedback has been positive.

An Inspirational Way of Promoting Recovery

I was first introduced to the R&W College when I was sent on a training course to learn more about how it worked. It was on this course that I realised the enormous benefits it had for those attending the courses and this was for two reasons.

Firstly it bridges the gap between treatment and actively feeling a member of the community again. Secondly it gives people the belief that by involving themselves with the College courses they will be able to achieve a more positive future for themselves. It is also an important factor that the courses are so wide ranging, encompassing “understanding your illness” to “managing your personal life.” Furthermore there has been untold value in having those with learnt experience running the courses.

Having experienced being part of the College as a family carer, I was then given the opportunity to apply to become a trainer. I have always felt that the R&W College has a lot to offer carers and as the whole process has helped me make sense of my own life and issues I felt enthusiastic about passing on my experiences to other families. I completed the training and applied to become an Associate Peer Recovery Trainer and was delighted when I got the job.

As an Associate Peer Recovery Trainer I have seen at first hand how much the attendees have got from coming to the College. It has given them the belief that recovery and fulfilling their ambitions in life is more than just a dream.

Hope, Control and Opportunity are exactly what this College stands for and puts into practice so well. It is a marvellous example of how joining up medical and educational care can give people the feeling that there is something to live for. Long may it continue to flourish.

**Veronica Kamerling - Carer, Student and Peer Trainer
Central and North West London Wellbeing College (2015)**

2. The effect of Recovery Colleges on staff who attend them

Although most evaluation of Recovery Colleges has focused on the impact on students who face mental health challenges, mental health practitioners also attend Colleges.

Perkins et al (2017) surveyed 94 mental health practitioners who attended the Norfolk and Suffolk Recovery College. It was evident that the Recovery College was as popular among students who were staff as it was among people who use services. 93% of staff students said they would recommend attending the Recovery College to colleagues. They cited as the primary reasons for their positive experiences co-learning, co-production and co-facilitation and the content of the courses. Staff particularly valued the co-learning experience in which people using users, staff and carers shared experiences.

The majority attended for their clinical learning/practice with the next most common reasons being for their own personal wellbeing, learning and recovery or to support a service user or carer. After attending, staff reported being more positive about mental health and recovery, understanding the meaning of recovery, feeling more hopeful, and reducing barriers between us and them. They also reported a positive impact on how they supported others in their work including increased skills and empathy.

However, 63% also reported that their own morale and personal wellbeing improved: they felt more connected with themselves and their own wellbeing; the College gave them a safe space to reflect on their own wellbeing and reduced the stigma of being a staff member with mental health challenges (there were no negative impacts reported).



Mental health practitioners in other services have also reported that the Recovery College has provided support with their own mental health challenges and in Solent Mental Health Trust information about the Recovery College is given out to staff with emotional distress who access the Occupational Health Service.

“The Recovery College has been a catalyst for me in so many ways: it has helped me to feel comfortable to ‘come out’ about my own mental health challenges, it has made me a much better practitioner in the way that I support others, and it has helped me nurture and love myself and given me permission to believe that I matter too, thank you for all that you do to challenge the stigma of mental health”

“The Recovery College has been such a supportive and nurturing space for me to get back on track and after spending time in the Recovery College environment I now feel energised and as though my batteries have been re-charged, thank you!”

**Recovery College East,
Cambridgeshire and Peterborough
NHS Foundation Trust, staff students**

Perkins et al, (2017) Four themes emerged as reasons for the positive impact of the Recovery College on their own well-being:

- **Connectedness:** staff students reported being more mindful of themselves and their own well-being needs: *“it helped me connect with myself”, “it made me recognise and address other areas in my own life that were causing anxiety and distress.”*
- **Self-care:** they felt encouraged to take care of themselves and reported using the skills they had learned
- **Safe space:** the Recovery College offered them the opportunity to reflect on and share experiences without judgement.

- **Sense of competency and increased morale at work.** Staff students felt better able to support service users by passing on learned skills. They also reported feeling more inspired and hopeful about recovery for the people they work with.

Sommer et al (2017) replicated these findings and reported that staff particularly valued learning more about the expertise of lived experience. Staff reported increased hopefulness and empathy, and appreciation that recovery was different for everyone. The Recovery College boosted staff morale and job satisfaction, and reduced stress and burden.

Newman-Taylor et al. (2016) explored the perspective of all students - service users, carers and staff – and found that all described the benefits of connecting with others in new ways; being able to reflect on stuck-ness and become more hopeful and widening horizons and expectations. They highlight the importance of co-production as the key.

“The Recovery College is ‘food for the soul’ and whenever I come to the College I feel nurtured, valued and energised! Thank you.”

“Something about the environment has left me feeling empowered and having permission to change the way I work, and challenge my assumptions about mental health. This is important, because the professional development opportunities within my profession are yet to really embrace and promote recovery. It’s happening, but I think it’s being driven by Recovery Colleges across the UK.

Thank you for all your support and encouragement, this has really affirmed how to change my clinical practice. At times I’m treading into what seems unknown, it’s been important to see footprints left by others walking the Recovery path ahead of me!”

**Recovery College East,
Cambridgeshire and Peterborough
NHS Foundation Trust, staff students
(Tingey and Gilfoyle, 2015)**

3. The effect of Recovery Colleges on the trainers who facilitate the workshops and courses

Recovery Colleges appear to have a positive impact on those who work as peer and practitioner trainers. In particular they valued the experience of co-production and found their own well-being improved.

Skinner and Bailey (2015) cite a survey of 17 practitioner trainers and 16 peer trainers. Both reported improvements in their confidence and self-esteem; they valued the experience of co-production and the learning opportunities this afforded; they became more aware of the need to look after themselves and enhanced their own wellbeing; and they felt supported by the College. Peer trainers also reported that working at the College had led to reductions in their use of services and that it improved their material wellbeing. However, challenges were raised about balancing time for different roles; managing difficult classroom interactions; some classes being cancelled due to insufficient signposting and practical issues around venues and IT.

A survey by Solent (2014) similarly found that trainers valued co-production and found the work satisfying; that they had learned more about recovery; their own recovery and wellbeing had improved and that it had altered how they worked in other aspects of their job and life. They also noted challenges with time pressures.

Gill (2014) focused on trainers' experience of co-production. Both peer trainers and clinicians valued the process of co-production personally and for transformation of the mental health system. Peers felt enhanced self-esteem, personal and professional growth, increased sense of purpose, hope and meaning. However, they also reported challenges in making a reality of co-production: the process could feel unequal depending on the individuals involved. This highlights the need for all trainers to have support and training specifically including recovery and co-production.

Working at the Recovery College has been inspiring and rewarding and fun, but also stressful, time consuming and hard work and it can be difficult to balance work at the College with the other demands on my time.

I have found working at the Recovery College transformative. Not only have I learned from peer trainers and students about their perspectives on mental health, recovery and self-management but I have also learned about myself. During the induction at the start of our Recovery College each peer talked about their lived experience as part of introducing themselves. As it came to my turn I also chose to speak of my own lived experience and other mental health professionals followed. This was challenging and emotional but also life affirming and was part of integrating different aspects of myself and becoming more fully me. The Recovery College has been one of the prompts for our Trust to start to genuinely value lived experience, not only of peers, but of all staff. It has been a catalyst for reducing the perceived differences between people who work in and who use services or are relatives of people who use services. Indeed, we have discovered that many of us have all three experiences.

A mental health practitioner trainer at Sussex Recovery College

Co-producing and co-delivering courses with service users, Recovery College East staff and volunteers has changed the way I work. It has been the way I've come to understand what Recovery actually means. It has happened gradually through many conversations, and witnessing other people interacting with each other in ways that promote empowerment, offer choices and recognise strengths, ambitions and goals.

Mental health practitioner trainer at Recovery College East, Cambridgeshire and Peterborough NHS Foundation Trust



Working at the Recovery & Wellbeing College has literally changed my life, as well as the way I view myself. Now I feel that I am contributing to the world and making a difference after years of only ever being on the receiving end of support. I have been able to turn difficult experiences into something positive and share my experiences in a way that promotes hope and a sense of possibility in others. Discovering that I have experiences and ideas that are of value to others has transformed the way that I see myself. I now have a belief in myself and can appreciate my own strengths and skills, something which I really struggled with before becoming a peer trainer. Now an important part of my role is to help others rediscover their own strengths and skills, to develop more self-management skills and to have more self-compassion; all things that have been an important part of my recovery journey. My recovery is still a work in progress, but even I am proud of how far I have come. At one time I believed I would never work again, yet having a job, an income and being part of a work team have all been so important in my own recovery. At one time I was going in and out of the inpatient unit, now I am still going in and out, but this time it is to deliver Recovery & Wellbeing College courses and I think of that as real progress!

A peer trainer at Central and North West London Recovery and Wellbeing College

4. The broader effect of Recovery Colleges on the culture and practice of mental health services more generally

While most Recovery Colleges report anecdotal evidence of the ways in which Recovery Colleges can serve as a catalyst to promote recovery-oriented practice and co-production more generally across the mental health services of which they are a part, there have, to date, been no formal evaluations of this broader impact. However, there are suggestions that they do foster changes in attitudes and practice that extend beyond the boundaries of the College itself.

Perkins *et al.* (2017) report that mental health staff who attended courses at the Recovery College said that, as a consequence of this experience, they better understood, and felt more positive about, mental health and recovery and 88% said that it had a positive impact on their practice by increasing their skills and empathy and breaking down ‘them’ and ‘us’ barriers.

“co-learning was linked to an increased sense of connectedness and parity with service users, increased empathy and understanding. Learning alongside service users as equals appeared to encourage staff students to understand and appreciate their perspective, recognise commonalities and reduce barriers.”

(Perkins et al, 2017, p22)

“Attending a Recovery College course is the best way to learn about recovery and working with people with mental health challenges.”

(Sussex Recovery College staff student)

“The Recovery College has been such a supportive and nurturing space for me to get back on track and after spending time in the Recovery College environment I now feel energised and as though my batteries have been re-charged, thank you!”

(Recovery College East, Cambridgeshire and Peterborough NHS Foundation Trust, staff student)

However, it is not just the direct impact of the Recovery College on staff who have attended courses that may be important in changing practice. Indirect experience of supporting people who had attended the College may be equally important in effecting changes in attitudes and practice. Rinaldi and Suleman (2012) compared the attitudes of the 66% of care co-ordinators who were supporting people who had attended the Recovery College with the 34% who had no-one on their caseload who had attended. Those who were supporting at least one client who had attended the Recovery College were significantly more likely to view self-management as important and significantly more likely to believe that people are capable of becoming experts in their own self-care. Sommer et al (2017) emphasised the potential of the Recovery College to challenge deficit based approaches, power dynamics and stigma within mental health services.

The impact may extend beyond the College itself. Anecdotal evidence from at least three Colleges have found that peers from the College working in ‘hot desk’ areas (where they work alongside other staff who are not involved in the College) had a positive impact on the attitudes of these staff.

5. Challenges and barriers to attendance

Attendance at Recovery Colleges is around 60-70%, in keeping with that of adult education. Dunn *et al.* (2016) interviewed students who had missed classes. The most common reasons for non-attendance included:

- **Personal factors** like physical illness; competing commitments or life events; worries about other students or classroom disruption and psychological wellbeing particularly anxiety.
- **Recovery College factors** reducing attendance. These include inconvenient location, time or date of the course and poor communication from the College.

Students suggested attendance might be improved by text or other reminders on the day before, or day of, the course; talking about attendance, learning goals and support needs as part of an Individual Learning Plan; orientation meetings or individual meetings with a tutor; help with travel costs; and buddies to support students to attend class.

Additionally, it was suggested that phone calls by a tutor when students missed a class might be helpful. Although the study was based on a sample of only 16 students, the findings are consistent with other research in health and education.

Zabel et al. (2016), in their study of the experience of students (people with experience of mental health problems, relatives/carers and mental health staff) identified a number of barriers to engagement including not being aware the College was there, disappointment when courses were over-subscribed, and students’ “stage of recovery”.

There may be additional challenges with attendance in more rural areas. Burhouse *et al.* (2015) describe temporary ‘pop up’ Recovery Colleges in local Colleges in rural areas. To overcome issues of not having the support associated with a Recovery College base, they added the option of up to three coaching sessions, provided self-management workbooks, and offered a café



style space for socialising. They learned there was a need to consider the hurdles students face in attending, such as transport and childcare, and psychological issues with confidence. They also highlight challenges associated with the wide educational range of students from people with literacy issues to those with doctorates and the need to pay attention to this when planning courses. They recommended work on progression and transitions out of the College and links with mainstream education and library services. In this context, it is interesting to note that in rural areas of Northern Ireland explicit partnerships have been formed with the Library Service and courses are held within libraries.

WHEN IS A RECOVERY COLLEGE NOT A RECOVERY COLLEGE?

The 8 key principles of a Recovery College outlined by Perkins et al (2012) and the critical dimensions of success described by McGregor et al (2014) were not designed to prescribe what people should do, but rather to provide a framework for local creativity and ownership. It is undoubtedly the case that such creativity has occurred. However, as different models and approaches emerge, the question must be asked ‘when is a Recovery College not a Recovery College?’ (see Perkins and Repper, 2017). When does deviation from these principles mean that a service can no longer be described as a genuine Recovery College? This is important in evaluating the impact of Colleges: it is necessary to have some idea about the model that is being evaluated. It is also important because Recovery Colleges have not been without their critics, most candidly described by Recovery in the Bin (2017). Such criticisms include the assertion that Recovery Colleges:

- Demand compliance and are prescriptive about how people should approach the challenges they face and leave no room for further reading, questioning or dissent.
- Offer a curriculum that is not evidence based: they are a cost cutting alternative to more effective services and evidence based therapies and interventions.

- Do not genuinely reflect equality between mental health practitioners and those who use services or equally value the expertise of lived experience alongside professional expertise (e.g. different rates of pay for peer trainers and mental health practitioner trainers).
- Become segregated mental health ghettos – an alternative to mainstream Colleges for those with mental health challenges – which infantilise those who use them.
- Represent a manifestation of individualised neo-liberalism: ignore the social, economic and political context of people’s lives and attribute mental distress and ‘failure’ to rebuild your life as individual failings.

Such challenges are important, but it could be argued that many result from experiences of ‘Recovery Colleges’ which have moved away from the original principles and success criteria. Over the last decade it has become clear that it is not easy to adhere to these principles given the prevailing culture, organisation and financial environment within services.

1. Educational principles

The prevailing narrative around mental health and 'illness' is one of treatment and cure. In such a context, the educational principles on which a College is based challenge traditional orthodoxy. Professionals are accustomed to assessing a person's needs and referring them to different types of service or therapy. It is tempting for them to do the same with Recovery Colleges. It is not uncommon for potential students to say 'my CPN said I must come on this course' or 'what happens if someone with a diagnosis of schizophrenia' enrolls for a 'Living with Depression' course? (Maybe they are interested in understanding more about depression. Maybe their Mum is depressed. Maybe they are feeling low.) College principles dictate that access is not determined by referral but by choosing courses from a prospectus, in conjunction with a personal tutor if they require assistance in exploring the different possibilities. Meddings et al (2014) found that students with mental health challenges particularly valued the choice and control offered by a Recovery College and found it empowering to be able to select what they want rather than have their needs prescribed by a professional.

It is therefore critical that steps are taken to engage mental health workers and services across the mental health diaspora with the principles and operation of the Recovery College: there is a big difference between someone saying 'you might be interested in having a look at this prospectus – perhaps there are courses there that you might find interesting' and 'you self-harm, therefore you should go on an 'understanding self-harm course'.

There are numerous ways in which a therapeutic, as opposed to an educational, orientation can creep into Recovery Colleges.

For example, attention to language used in the College is essential. Discussion of things like 'insight', 'stuckness', 'transference' and 'negative thinking' can all betray a therapeutic perspective. Sometimes courses become 'therapeutic' and take on the features of a

therapy group rather than an educational opportunity. For example, in one Recovery College, a peer trainer was particularly interested in a particular therapeutic approach, so a course relating to living with bipolar disorder was couched in terms of this therapy. It may be reasonable to offer a course introducing people to the principles of therapy but a course where content and form are determined by these principles strays into the realms of therapy. This jeopardises the power of educational relationships to enable people to explore their own perspectives and solutions.

In an era when resources are being cut, some Colleges have been tempted into compensating for deficits elsewhere in the system, for example organising social events, providing a place for people to be. It is understandable why Colleges may be tempted to organise social activities if they can see that their students are lonely. Invariably, people get to know each other within the College and often meet up socially outside, but this is quite different from the College organising social events. It is equally tempting to offer one to one counselling to someone who is distressed or to help a person who is having difficulty with, say, their benefits to resolve these. Offering a workshop on welfare benefits or providing information leaflets about counselling services is one thing, but offering individual help and counselling fundamentally changes the relationships within the College. It is the very different relationships that exist within an educational environment that lie at the heart of the Recovery College's power to assist people to explore their possibilities and rebuild their own lives.

Recovery Colleges have an important role to play, but if they try to do everything the unique power of the learning environment in enabling people to grow and develop is lost. Individual and group therapy may be valuable but they are different from education and cannot be provided by a Recovery College without jeopardising its unique identity.



A key feature of the Recovery College is the very different relationships it offers and distinguishes it from more traditional ‘psycho-educational’ approaches. Recovery Colleges provide a setting where people can access the collective wisdom of trainers and fellow students. They enable people to explore different perspectives and world views, foster mutual learning and encourage students to work together to find their own solutions.

2. Coproduction and collaboration

While coproduction in all facets of operation, curriculum design and facilitation is a core premise of the Recovery College, the bringing together of the expertise of lived/life experience and mental health practitioner/subject expertise on equal terms has also proved challenging to achieve in practice.

The belief that, at the bottom line, the ‘professionals know best’ remains entrenched in mental health services and is ultimately reinforced by the existence of compulsory detention and treatment. In such a climate, genuine co-production is difficult and is too easily replaced by a more tokenistic ‘involvement’ of people using services’ within a framework prescribed by practitioners. This can lead to a stifling of dissent where the expertise of lived experience is only accommodated if it accords with the prescriptions of professionals.

Gill (2014) describes some of the early challenges faced within the South Eastern Sydney Recovery College where some peer trainers reported that the co-production process could feel unequal depending on the individuals involved. These were resolved by putting in place robust course development agreements and fidelity criteria, plus a comprehensive ‘train the trainer’ programme for peer and clinical educators (Sommer, 2017). King (2015) describes barriers to co-production including funding, being able to evidence outcomes and growing to scale. These difficulties were overcome by learning from others, engaging students and partner organisations, obtaining finance, keeping recovery principles central, support from senior management and Trust boards, training in co-production and the personal qualities of those involved.

Conversely, in some Recovery Colleges, efforts to redress the balance between peer and professional expertise has led to courses being largely developed by peers with professional expertise being marginalised and somewhat tokenistic. While the expertise of lived experience is important, peers do not have a monopoly on expertise, and it is important that participants can access the experience of mental health practitioners and the research evidence as well. If they do not, then Recovery Colleges are open to the accusation of lacking an evidence base. For example, in a course describing different treatment options it is important that people have access to both the lived experience of these and the National Institute for Health and Clinical Excellence research based guidance if they are to make informed choices.

At a practical level, some areas have been tempted to bring into the College professionally designed/run courses, or peer designed/run courses that already exist in different parts of the statutory or non-statutory mental health system with only cursory modification (e.g. introducing a peer co-facilitator into a professionally designed course or vice versa). This is a mistake. Courses developed by professional, or peer developed/run courses, may be valuable, and may continue to exist within other parts of the system, but they are not founded on the co-production that lies at the heart of the Recovery College and do not enable participants to access both practitioner/subject expertise and lived expertise. It is the process of co-production that lies at the heart of the transformational change embodied in Recovery Colleges.

Failure to value equally knowledge and understanding derived from lived/life experience and from practitioner/subject expertise often arises from challenges in accommodating differences of opinion. For example, the firmly held beliefs of both peers and professionals about the nature and origins of mental health challenges and traditional debates between the range of 'organic' and 'social' models. It is sometimes assumed that in the process of co-production, peers and mental health practitioners must reach agreement about the perspective to be presented. Students do not need to be 'spoon-fed' with one 'right answer'. Recovery Colleges must be capable of accommodating difference: there is no one, correct theory, understanding or route to recovery. This means that facilitators do not have to reach agreement about content, but instead present students with different perspectives and frameworks for understanding mental distress, and allow them to consider and develop these and make up their own minds.

In this context, it is important that practitioner trainers and peer trainers draw on more than their own personal preferences and beliefs. A mental health practitioner trainer might be expected to draw on the different professional schools of thought and research, including those that they do not personally share. Similarly, a peer trainer might be expected to draw not only on their own lived experience but that of other people with lived experience and the peer literature in describing the range of different ways of understanding and approaching challenges.

Another challenge for Recovery Colleges is the ongoing nature of the co-production process. It is tempting, and often organisationally expedient, to consider that co-production is 'done' once a course has been collaboratively developed. There is a danger that courses and workshops become fixed and manualised. The essence of co-production is that it is an iterative process involving peer and practitioner/subject specialist trainers and students in refining/reviewing the content and in identifying (and coproducing) new courses as the need arises and thereby developing the curriculum.

King (2015) found only 2 of 23 respondents mentioned co-production involving students. In a well-functioning Recovery College, trainer and student feedback will be used to review and revise courses and workshops and to develop new ones: breaks between terms are often used for this purpose. It is not uncommon for students to say 'yes, this course was good, but it did not cover X', and then become involved in co-producing a course on X. However, this sort of a dynamic process can be hard to achieve in practice and within the boundaries of available resources.

Co-production outside the immediate development of courses and curricula can be equally challenging. The commissioning and service environment often demands decisions at short notice and this can pose challenges to co-production. In order to get around these, it is often necessary to have a steering group of people with lived and professional experience who are acquainted with the various systems and structures and are therefore able to participate in generating solutions, and writing proposals, at short notice. It is important to remember that different skill sets (among peers and professional/subject) experts are required to participate in different facets of Recovery College operation: teaching skills, design skills, marketing skills, evaluation skills, quality assurance skills, organisational skills ... It cannot be assumed that any peer, or any mental health practitioner possesses the necessary skills, therefore selection for different roles needs to extend beyond learnt or lived experience of mental health challenges.

The process of co-production is a key hall-mark of a Recovery College, and experience suggests that all need to pay close attention to the training of those involved in the process and establishing mechanisms that foster and facilitate it.



I have found the process of co-producing a course to be an inspiring experience. The process always starts with a mixed group of people with lived experience and practitioner experience and a blank sheet of paper. At times, early in the process with a newly formed group it can start to feel like a battle of wills, especially over decisions about what to include in a course. But I've found that these difficult interactions can provide great learning opportunities if individuals are able to have transparent discussions about what's happening and power sharing etc. As the process progresses it is like we develop a shared language and a shared frame of mind about how we relate to each other as well as a respect for transparency. Both peers and mental health practitioners may need to go away and collect evidence beyond their own experience from the peer and professional literature.

I have seen changes in how practitioner trainers use their skills and knowledge and how peer trainers bring in and utilise their lived experience. A shift in perspective occurs. The barriers between people get broken down and we realise that what's important is what individuals 'bring to the table' rather than their labels or identification with a role and status.

But the co-production process does not stop once the course is developed. Students give feedback, trainers reflect on what works well and what does not and the co-production process continues in refining and developing the course.

A Senior Peer Trainer

3. Recovery-focused: strengths based, person-centred and progressive

While most Recovery Colleges have succeeded in creating a recovery-focused, strengths based, hopeful environment, there is a risk that some people will be alienated by what appears to be a failure to acknowledge the magnitude of the traumas and losses that they have experienced and the challenges they face. This can leave some feeling personally responsible for their 'failure' to feel positive and hopeful about their future.

"Challenge those self-defeating beliefs! You too can recover! ... We have pictures with uplifting words like 'HOPE' and 'EMPOWERMENT'. Your life doesn't matter. Your experiences don't matter. ... We'll blame your distress on you. YOU must do BETTER." (Recovery in the Bin, 2017 p2)

While it is important for Recovery Colleges to offer images of possibility, it is important to recognise

"... the very material barriers and disadvantages: poverty, homelessness/ poor and unstable housing, ever present

fear of having the meagre benefits on which you survive withdrawn, unemployment, social isolation and all the prejudice and discrimination that abound." (Perkins and Repper, 2017 p70)

Such disadvantages require not individual change but collective action: changing the world rather than changing the individual. As Kinn (2016) – a peer trainer at a Recovery College – discusses, **it may be important for Recovery Colleges to adopt a social model of inclusion** (Repper and Perkins, 2012; Perkins and Repper, 2012; Perkins, 2015): **recognise the barriers that exist, enable people to understand the impact of these and (both individually and collectively) assert their rights as citizens.** Some Recovery Colleges have begun to do this in courses and workshops like "Mental health discrimination and stigma" and "Citizenship and voting rights" and "Making Human Rights Work for You", and "Challenging Stigma", and "Discrimination, Marginalisation and LGBTIQ Mental Health" but such examples are few and far between.



There is also a danger that Recovery Colleges become day centres in all but name: traditional groups are relabelled 'courses' but a genuinely co-produced, progressive, recovery-focus is lacking. This has proved a particular problem when the Recovery College has developed from a more traditional day service.

In the curricula of some Colleges (whether or not they were developed from a day centre) a number of non-recovery focussed courses have emerged including learning to use a sewing machine, kayaking and various art and dance courses. These may be important/ of interest to some people and dilemmas can arise between the purpose and nature of a Recovery College and the co-production of the curriculum. Mental health practitioners and peers who have been accustomed to the opportunities of traditional day services may well request such social and leisure activities – and these requests should not be ignored. However, the question is whether these are best located within a College. When Recovery Colleges stray beyond their recovery-focused, educational remit then they become a different service with different relationships and a different purpose and can cut people off from communities rather than enabling them to become a valued part of those communities alongside other citizens. There are other extremely effective service models that can enable people to access social and leisure opportunities that exist in communities, for example 'Creative Minds' in South West Yorkshire (Walters, 2015).

Recovery College East within Cambridge and Peterborough NHS Foundation Trust encountered this dilemma when students were asking to co-produce more creative/ art focused courses which felt more aligned to a day service model. Their compromise was to co-produce a course called "creative steps forward" which helped students explore creative and recovery focused courses and activities in the wider community, without the need to deliver these in the Recovery College.

The progressive nature of Recovery Colleges is critical if people are not to be trapped in a segregated, College treadmill taking one course after another, year after year. As Meddings et al (2015) found, students said that progression enabling people to move forward was an area that could be improved. Individual Learning Plans based on a person's wishes and aspirations can be an effective vehicle for achieving this. Similarly, provision of information and sign-posting may be important, as well as emphasising the progressive nature of the process and celebrating 'endings' in the form of graduation events.

Quality assurance mechanisms are critical if a Recovery College is to preserve its unique role and relationships: all involved must understand what these are and creativity must operate within a College remit. Where the co-production process strays into other areas these may need to be explored outside the College.

4. Community facing

One of the most important features of a Recovery College is that it is community facing. One of the greatest dangers is that it becomes a separate, segregated place that, albeit unwittingly, fosters and maintains social exclusion. Recovery Colleges must be a part of their communities, not apart from them. Colleges can enable people facing mental health challenges to become a part of their communities and increase the capacity of those communities to understand and embrace those who experience such challenges. They can therefore contribute to the creation of communities that can accommodate all of us.

A community orientation may be achieved in a number of ways.

- Some Recovery Colleges have drawn on subject expertise available in the communities (like employment experts, College tutors, welfare benefits experts, housing experts, the police) to co-produce relevant courses. However, others have relied almost exclusively on the subject expertise available within the mental health system. This not only deprives



students of access to important expertise but the opportunity to link with communities, and break down the fear and prejudice that exists, is lost. The breaking down of prejudice can operate in two ways – enhancing understanding and acceptance is a two-way street. Many people facing mental health challenges may be wary of engaging in community activities – meeting people from other agencies can allay such fears. On the other hand, people from community agencies may be wary of those with mental health challenges because of the myths and stereotypes that abound. Working collaboratively with people who experience such challenges in a College setting can serve to increase understanding and acceptance.

- While many Colleges offer courses directed towards enabling people to develop the skills, confidence and knowledge to participate in different facets of community life, the simple provision of courses may be insufficient unless it is accompanied by an Individual Learning Plans. Many Recovery Colleges have found these valuable in enabling people to think about goals and aspirations that are important to them and assisting them to select courses in order to move forward in their lives. This is where the role of the Personal Tutor can be particularly important (as they are in mainstream educational settings) – while many Colleges have developed such roles, they are not universal. However, it is important that the process of developing Individual Learning Plans does not act as a barrier to accessing the College. Some Colleges have developed complex and extensive learning plans that can put off some potential students – including students who are members of staff. One size cannot fit all. Some students may simply want to gain a greater understanding of, for example, living with depression, in which case a simple learning plan involving a single course may suffice. Others may be looking for greater assistance in their personal recovery journey and need to consider how the College relates to broader life goals.

- The final way in which Recovery Colleges can be important in breaking down the barriers that divide ‘mental health services’ and those who use them from the community is by people learning together. A Recovery College should be a community resource for anyone experiencing the emotional challenges associated with difficult life events (like divorce or bereavement) and/or those supporting/serving people with mental health challenges in different settings (like community pharmacists, employers or Colleges). If it is, then the barriers between ‘mental patients’ and ‘the community’ are eroded and greater mutual understanding is promoted. While aspiring to achieve this, the reality is that there are often significant barriers to translating this aspiration into reality (see below).

However, in their quest for a community focus it is important that Recovery Colleges do not cut themselves off from mental health services. They **must be integrated both with mental health services** (and the expertise that exists within them) **and communities** (and the expertise and opportunities that exist within them and **serve as a bridge between the two**). It is by doing this that they can help people on their journey of recovery and enable people to access and thrive in communities outside the mental health ghetto. **It is only by acting as such a bridge that they can both contribute to the recovery-focused transformation of services and the creation of communities that can accommodate mental distress.** One way of achieving this is by providing courses in dispersed community settings. For example, courses developed within the Recovery Colleges can be run in community settings: in cafes, in sports centres, in community groups like, for example, those provided within various ethnic minority, Deaf, gypsy and traveller communities. They may also be run in different languages/co-delivered by experienced trainers who speak those languages: South Eastern Sydney Recovery College, for example, offers a range of courses in different community languages. This makes them more accessible in terms of content, location and language to people who might otherwise be excluded.

5. Inclusive: for everyone

If Recovery Colleges are to be genuinely inclusive and open to all, several areas need to be addressed.

First, Recovery Colleges must **welcome the diverse range of people who use mental health services**. This can prove a challenge. Some Colleges have been tempted to set explicit criteria for determining whether people are 'ready'/'appropriate' to attend including diagnostic criteria, behavioural requirements - 'must be able to concentrate', 'must be able to participate in a group' – and the performance of 'risk assessments'. The majority of Colleges have not adopted such criteria. However, inclusivity is not simply the absence of exclusion criteria. It is also about positive action in creating an environment, and making the 'reasonable adjustments' necessary to ensure that the College is accessible and acceptable to all: people in inpatient wards and secure services as well as those living in the community; people with physical impairments and learning disabilities/difficulties; people of different faiths and cultures; different ages and genders; gay, lesbian and transgender people ...

Some Colleges have begun to address some of these issues. For example, providing the adjustments and support that people with physical impairments and learning disabilities may need; running courses on wards and in secure units for those who are compulsorily detained; and organising courses directed towards specific groups like women only courses for those who have experienced sexual abuse or those addressing the specific needs of men, older people, younger people etc. However, most still have some way to go: as in any services, explicitly reaching out to under-served groups and communities and exploring with them how the College could be more accessible is critical.

Second, Recovery Colleges must be **accessible to the relatives and friends of people experiencing mental health challenges**. Some Colleges have recruited 'carer' peer trainers and organised courses explicitly directed towards those who are supporting someone with mental health

challenges or a diagnosis of dementia. Some Colleges have offered 'early bird' courses specifically reaching out to carers. However, other issues like timing, location and support available may also be important for those relatives and friends who are working or whose caring responsibilities make it hard for them to attend courses.

Third, in order to break down 'them' and 'us' barriers, it **is critical that staff providing services (in both statutory and non-statutory sectors) learn alongside those facing mental health challenges**. Some Recovery Colleges have large numbers of staff attending courses, and the feedback from such staff is extremely positive (see Perkins et al, 2017). However, the 'them' and 'us' barriers that are so entrenched in services mean that many Colleges serve few, if any, staff students. Actively publicising the Recovery College among staff and encouraging staff to attend (including within the Appraisal Process and Continuing Professional Development Plans) is important. In this context, it may be important to emphasise that staff can gain as much from the co-learning opportunity as they can from the specific topic of the course. Staff interviewed by Perkins et al (2017) said that they particularly valued the sharing of ideas and insights with people using services and that this increased their understanding of the challenges people faced and the process of recovery. Some Colleges have facilitated this by ensuring that staff can access and register for Recovery College courses through the usual mechanisms that they would access other forms of staff training.

Third, to be inclusive, Recovery Colleges need to be accessible to those facing emotional and mental health challenges who do not use mental health services and people in the broader community. This is becoming increasingly important as greater responsibility for the treatment of mental health challenges rests within primary care. In places, like Northern Ireland, where barriers between primary and secondary care, and between health and social care, are minimal it has been possible to make Recovery Colleges genuinely open to all.



However, in places where the divides between services and funding streams are more clearly delineated, problems can occur. For example, if funding is obtained through secondary mental health services then there are pressures, supported by performance indicators, to restrict attendance to people using such services. Similarly, the contracts awarded to voluntary sector organisations may stipulate that they can only serve specific groups of people. Such funding constraints can also act as a barrier to staff attending Colleges.

Services have adopted a number of ways to try to circumvent such barriers, for example:

- Partnership working between secondary mental health services and voluntary sector providers who can serve a broader range of people.
- Basing the Recovery College in an educational establishment that serves a wider population.
- Gaining agreement that people may continue to use the Recovery College for a year after they leave secondary services.
- Gaining contracts with primary care as well as secondary care, and indeed social and employment services, so that a broader range of people can be served.

Nevertheless, the restrictions imposed by funding demarcation continue to present problems in ensuring that Recovery Colleges are really open to all.

DEVELOPING RECOVERY COLLEGES: LEARNING FROM EXPERIENCE

In addition to the challenges in implementing the principles and critical dimensions of success outlined above, the experience of developing Recovery Colleges has raised several issues relating to who should provide them, where they are located, staffing arrangements and leadership issues

1. There has been much discussion about who should provide the Recovery College.

There is no single model for providing a Recovery College. Inevitably they involve 'the art of the possible' and are dependent on local resources and opportunities, local geography and local interest and commitment. Recovery Colleges inevitably involve partnerships and collaborative working across agencies, and there are many possible players. Across the UK, central players include

- Specialist mental health services
- Primary Care
- Non-statutory – voluntary sector – mental health services
- Education providers (Universities and Colleges)

- The Library Service

But many other local agencies may be involved like drug and alcohol services, employment agencies, housing providers, sports and leisure services, refugee/asylum seeker organisations, police, University of the Third Age, Citizens Advice Bureaux, debt advisory services, ... the possible list is almost endless!

In terms of leadership and organisation, to date a number of models can be discerned. Although strong opinions exist on all sides, there is no evidence to suggest that any one is 'better' or 'more effective' than others – each has their pros and cons.



- **Secondary Mental Health Services with input from other organisations and agencies.** This was the model adopted by the original Recovery Colleges and has several advantages. They are more likely to be recognised as a core part of the mental health service offer and be accessible to people with more serious mental health challenges who use such services and the staff who provide them. Because they are embedded within secondary mental health services, their transformative power to model and promote recovery-focused change across the service system is enhanced and many professionals within the system can be influenced by participating either as trainers or students. If they are a core part of secondary mental health services (where most mental health funding lies) their funding as part of the block contract for those services may be more stable.

On the negative side, they may be less accessible to those outside the secondary mental health system because their funding primarily derives from the secondary mental health sector, and people may not be able to continue to use the College after they have been discharged. Because of their connection with mental health services they may be perceived as stigmatising by some students (although this can be mitigated by ‘spokes’ operating in community settings). However, endeavours to offer a very different approach may be hampered by the prevailing culture of mental health services. Although they may have input from other organisations and agencies, the ability of such organisations to influence the culture and operation of the College may be limited.

- **Secondary Mental Health Services leading a formal partnership with other organisations, like non-statutory mental health services, organisations of service users and carers, education providers and the Library Service.** While sharing many of the advantages of Colleges provided by the statutory mental health services, such partnerships increase the range of expertise available,

foster community links, make the College available to a wider range of people and decrease stigma. They can also represent a way of addressing some of the challenges of more dispersed communities. As already described, a partnership between Health and Social Care Trusts and the Library Service in Northern Ireland has ensured a greater reach into rural communities and enabled the College to benefit from the wealth of facilities and resources that local libraries contain. Contracts and partnerships with primary care can increase the range of people who can access the College and partnerships with education providers can reinforce and extend the educational focus.

While such formal partnerships offer a wealth of possibilities, they may find it difficult to influence the larger, more powerful, secondary mental health service partner; it may be more difficult to encourage staff to participate as trainers; funding arrangements may be more challenging and precarious; and the rivalries involved in bringing together organisations with very different cultures and focus may present problems. The more organisations in the partnership the more challenging the task – most partnerships only involve two agencies – and success may well depend on previous working relationships between organisations and the individuals involved.

- **Other organisations leading in formal partnership with secondary mental health services** (with input from other agencies). Examples exist of non-statutory mental health services, user led organisations and educational establishments leading Recovery Colleges in partnership with mental health services. Such arrangements can have a number of advantages in reducing stigma attached to using the College, increasing community focus and creating a collaborative culture quite different from the clinical, treatment focused, approaches of traditional services. It may also be possible to attract different sources of funding not available to health services.



However, as the College is not seen as a core part of the mental health offer, its transformative power in relation to statutory mental health services is jeopardised. Funding may be more tenuous (often in the form of time-limited tenders) and it can be more difficult to secure the input from mental health professionals that is necessary for genuine co-production. In some places, Recovery Colleges are emerging with no formal partnership arrangements with mental health services – for services like this such challenges are magnified. There exist Recovery Colleges with a ‘professional’ perspective provided only by voluntary/non-government sector workers and no input from mental health professionals like psychologists, psychiatrists, pharmacists, social workers, nurses and occupational therapists. Subject specialist expertise, alongside the expertise of lived experience, is essential: for example, pharmacists on courses about medication and psychologists on courses about different sorts of psychological therapy. While a voluntary/non-government sector perspective is important, without the input of traditional mental health professionals, it is hard to say that the College is really bringing together professional expertise with the expertise of lived experience and the power of the Recovery College to transform mental health services is lost. Once again, existing relationships between agencies involved will be critical.

Whatever the local arrangements may be, it is critical to ensure access to both professional and peer expertise. If Recovery Colleges are to influence not only on the lives of those who use them but also the wider mental health system, it is also important that we think not only about community integration but also integration with mental health services.

2. There has been considerable debate about where a Recovery College should be located.

Some Recovery Colleges have been located on hospital sites. Unless they have a separate, distinct building/area then it is difficult for them to develop a clear identity and way of working that is distinct from traditional therapeutic approaches.

Where a Recovery College has a separate building/area on the hospital site they have been more successful in developing their identity and collaborative, educational, recovery-focused way of working. When they are located at the heart of services, they are visible to all and able to exert a greater influence on the system as a whole. They are more accessible to inpatients, and offer a familiar environment to others using secondary services. It may also be easier to engage mental health professionals who

work in hospital as both trainers and students. However, community links are more difficult and some potential students are reluctant to attend - especially those with no connection to mental health services and those who have had a negative experience of such services.

Where Recovery Colleges are based within educational settings, the environment may be important in reinforcing the identity of ‘student’ rather than ‘patient’. Community locations can offer a more ordinary, non-stigmatised, environment and better community links, but have greater difficulty in influencing the broader mental health system and engaging mental health professionals.

Solent Recovery College (SRC) opened in 2013. It is a partnership between Solent NHS Trust, Highbury Further Education College and Solent Mind. Students report that SRC's position within a mainstream college is a significant and positive part of their experience. The processes are aligned to ensure students are registered and able to access Highbury's resources. Solent Mind employ the 10 peer trainers, co-ordinator and administrator and around 20 Adult Mental Health staff (employed by Solent NHS) input into SRC based on their personal interest and expertise.

A rolling programme is offered by repeating the introductory course fortnightly to ensure student interest is matched with easy access. 34 different courses are delivered of 2 hour duration, progressing from single sessions to longer programmes. Over an academic year, 7 new students per week register with SRC. Around 70% will have ongoing or recent contact with secondary or primary mental health services with the remainder being friends and family or staff within the partnership organisations. Students receive a Certificate of Achievement for every 10 hours of completed study at an annual event which is well attended by family members. Year on year students consistently describe increased hope, improved ability to cope with their experiences and feel better able to navigate services. Tutorials are rich with discussions about the importance of the 'different approach [co-produced]' in SRC, the importance of learning from shared experience, a space to try new things (make friends, show vulnerability) and work at their individual pace. Around 7% of students progress into mainstream education courses within and beyond Highbury College, gain voluntary or employed opportunities. SRC prides itself on the value our staff place on SRC: trainers, with both lived and learnt experience, identify feeling motivated and inspired by their experiences working in SRC.

www.highbury.ac.uk/student-life/advice-and-support/solent-recovery-College

3. Who should the Recovery College staff team comprise and how should they be employed?

Recovery Colleges differ from one another in terms of their staff teams. It is probably fair to say that it is not possible to run a Recovery College effectively unless there is at least one person whose sole job it is to co-ordinate the College. While some Colleges have run for some time with a single core member of staff, if they are to be sustainable they probably require a small core team of people and a designated manager. In some Recovery Colleges, the core team primarily consists of personal tutors and administrators with the course facilitators drawn largely from sessional mental health staff who co-produce and co-facilitate specific courses with a range of associate peer trainers. In other instances, there are a group of permanent peer and mental health practitioner trainers employed on a full or part time basis, supplemented by a larger group of sessional peer trainers (paid on a sessional basis) and mental

health practitioners/subject specialist trainers providing input on a sessional basis.

If the College is to be able to tap into a broad range of expertise and exert a broader influence on the services practice of professionals, it seems to be important to involve a range of associate peer and mental health practitioner trainers. In some Recovery Colleges minimal or no use is made of sessional, peer and professional/subject specialist trainers and there is a risk of them becoming very separate from the services and communities of which they are organisationally a part. Ensuring that a larger cohort of mental health practitioners, peers and subject specialists from outside mental health services can contribute as trainers and students appears to be important in embedding the College within both organisation and community.



Engaging mental health practitioners in co-producing and co-delivering Recovery College courses can be a challenge in times of reduced funding for mental health teams and increased caseloads. Management support for mental health staff to contribute to the Recovery College is important as is consulting with mental health staff and managers, as well as people with lived experience, about the types of courses that might be beneficial. The experience of many Colleges is that, once staff have had the opportunity of engaging with the Recovery College, they enjoy and gain from the experience and are keen to negotiate time to contribute to it. If a large number of staff are involved, the time commitment for each one is reduced.

While not a substitute for mental health services, Recovery Colleges can reduce the pressure on teams by offering, in an educational format, some of the things that have hitherto been provided on a one-to-one basis. This has the advantage of enabling people to access professional/subject expertise and gain peer support in their journey. In this context, it may be important to set up mechanisms so that Recovery College attendance can contribute to teams meeting their Key Performance Indicators and other statutory requirements. For example, most teams have to achieve a target number of contacts: mechanisms can be established to ensure that Recovery College contacts can contribute to these targets.

There has been heated debate about the payment of trainers. All would agree that at least some peer trainers should be paid, but some feel strongly that this should be supplemented by the possibility of people choosing to volunteer, at least in the first instance. Some peers prefer to try out working for the College on a voluntary basis before taking the plunge of employment; some are concerned about the impact of sessional paid work on their welfare benefits and would prefer to work as volunteers; others are concerned about leaving benefits to take up paid work because they may be financially disadvantaged and face difficulties if they are unable to sustain their employment.

“As well as offering Recovery College East support, the opportunity to volunteer at the College also supports my long-term wellness. In committing to one or two days a week volunteering, I feel a responsibility to be there at the times arranged... a good first stepping stone towards hopefully regaining paid employment in the future.” (Volunteer at Recovery College East, Cambridgeshire and Peterborough NHS Foundation Trust)

On the other hand, others feel equally strongly that it is exploitative to expect peers to work for nothing while mental health practitioners offer training as part of their paid work (most professionals providing training, even on a one off basis, do this in working hours). They argue that failure to pay peer trainers devalues the expertise of lived experience and runs counter to the Recovery College philosophy of bringing together the professional expertise and the expertise of lived experience on equal terms.

Undoubtedly such debates will continue, and in an era of diminishing resources some may face a choice between recruiting volunteers and having no Recovery College at all.

Issues have also arisen about the relative rates of pay of peer and mental health practitioner trainers. Within the NHS, rates of pay for mental health practitioners are nationally determined against strict criteria and peer trainers rarely meet the criteria required for higher rates of pay under the ‘Agenda for Change’ rules. Similar problems sometimes exist if the Recovery College is provided within the education sector where rules govern the qualifications necessary for employment and recruitment to different grades. More flexibility exists within the non-statutory sector, however, rules governing grading structures continue to exist in many organisations and differentials remain if mental health professionals work as sessional trainers seconded from statutory services.

There are no easy resolutions to such issues, and debates and inequities are likely to persist, but whether paid or not the training and supervision of both peer and mental health practitioner trainers is an issue that must be considered if the quality of Recovery College courses is to be maintained.

4. Culture carriers: The importance of leadership

In all the successful Recovery Colleges that have been developed, local leadership has been critical. Sometimes the person leading the Recovery College has been a mental health practitioner, sometimes it has been someone with lived experience, often it has been someone with both types of experience. However, as well as the usual qualities of leadership, they share a passion for the task.

- ***They ‘get it’.*** They are imbued with a recovery-perspective and really understand the nature of a Recovery College, how different its approach and philosophy is from other types of service and what co-production really means. Without this it is easy for the College to drift away from its principles.
- ***They can ‘communicate it’.*** They can inspire others – both those within the Recovery College, people using and working in mental health services, people in agencies and individuals within communities and commissioners/those who hold the purse strings. The Recovery College is a very different idea – it challenges existing ways of thinking and doing – it will only be successful if the leader can sell the idea widely.
- ***They ‘don’t give up’.*** There will be many challenges and pitfalls along the way and someone will always be waiting to ‘throw a spanner in the works at the slightest opportunity. If a Recovery College is to become a reality, then there needs to be someone who is going to keep going, even when the odds are stacked heavily against them, and find ingenious ways around barriers that are presented.
- ***They can gain ‘an ear in high places’.*** They can earn the respect of those people who can make or break the College. This may not mean that the person has seniority in formal structures, but they need to be able to identify the key actors, without whose support the success of the Recovery College will be compromised, and form a constructive relationship with them.
- ***They are prepared to ‘have a go’ – take a leap of faith.*** Any form of co-production involves a leap of faith: believing that you can trust that the different people involved can come up with solutions; that you don’t have to have worked out ‘the answer’ beforehand; that there are different ways of doing things; that things will not always work out as you had planned and it is OK to make mistakes sometimes. This takes courage.
- ***They know ‘the direction of travel’ but don’t think they have all the answers.*** They are able to identify the strengths and possibilities in individuals at all levels – including those who may be opposed to the notion of a Recovery College. They are prepared to listen to, and take seriously what is said and think about how it might be addressed. They can share leadership and bring around them a diverse group of people who can make it happen.
- ***They never ‘rest on their laurels’.*** They are always looking for ways to build on and develop things and can inspire others involved to do likewise. The Recovery College is never a ‘finished product’ but a continually evolving entity.



A WORK IN PROGRESS

Ultimately, the most striking things about Recovery Colleges is how popular they have proved: most struggle to keep up with demand.

“I have moved further in my recovery in one term here than I have in the past two years in the mental health team.”

“I can’t believe what you have done for my son. I used to have to push him out of the door and he would cover his face. Now he goes out with his head held high.”

“I have discovered ... a wonderful, helpful and hopeful place that I know will be of tremendous help to me in moving forwards in my life.”

They remain a work in progress, however, over the last decade, a greater understanding has been gained about the **key defining features of a Recovery College**:

1. They are based on **educational principles** and do not replace formal individual therapy or mainstream educational opportunities.
2. **Coproduction, co-facilitation and co-learning** lie at the core of their operation: they bring together lived/life expertise with professional/subject expertise on equal terms.
3. They are **recovery-focused and strengths based** in all aspects of their functioning. They do not prescribe what people should do but provide a safe environment in which people can develop their understanding to keep themselves well and build skills and strategies to live the lives they wish to lead.
4. They are **progressive**, actively supporting students to move forwards in their lives both by progressing through relevant courses that enable them to achieve their identified goals, and by identifying exploring possibilities outside services where they can move on in their lives and work.
5. They are **integrated with their community and with the mental health services and can serve as a bridge between the two**: serving as a way of promoting a recovery-focused transformation of services more generally, creating communities that can accommodate mental distress and assist individuals to access and thrive in community settings.
6. “They are **inclusive and open to all**. People of different ages, cultures, genders, abilities and impairments, lesbian gay and transsexual people as well as to people in local communities who face mental health and emotional challenges (and long-term health conditions/physical impairments), people who are close to them and people who provide services that include those with such challenges. By learning together - on equal terms in conditions, where stereotypes are challenged and people can get to know each other (see Hewstone, 2003) – barriers can be broken down and genuinely inclusive communities promoted.

Clearly some Recovery Colleges have drifted away from these – by accident, design or force of circumstance – and some have argued it is time to formalise them into a set of manualised fidelity criteria. However, to do this, risks stifling growth, creativity and the ongoing process of co-production on which they are founded. There is always room for mixing the key ingredients together in new and different ways and adding different herbs and spices.

As ever, there is a need for more research, and there is more in progress², but it is important that this does not ossify what is a continually evolving creation.

“After attending courses at the CNWL Recovery College, I have felt empowered with knowledge about my condition, become more in control of my emotions, and have picked up quite a few skills to help me along way. The opportunity to share my experiences and interact with people who have similar life stories, feelings and struggles has probably been the most beneficial thing (and peer trainers are such an inspiration, reminding me that I am not just someone with a mental health condition and that there is a life beyond depression/ anxiety/ services).”

Thea in Central and North West London Recovery College (2014) Recovery and Hope. Personal stories from students and trainers at CNWL Recovery College http://www.cnwl.nhs.uk/wp-content/uploads/CNWL-Recovery-and-hope_-RC-Stories-Booklet_.pdf

“Ever since coming to the Recovery College, I have had immense support from learners and staff, which has encouraged me to develop my confidence, self-esteem and knowledge. I have also established new friendships and even consider myself to have close friends! All courses have played a part in my recovery journey. Since the very first course, I have never looked back.”

The Exchange Recovery College Barnsley. Learner and volunteer testimonies. <http://www.southwestyorkshire.nhs.uk/wp-content/uploads/2014/05/0295-Recovery-College-testimonials.pdf>

REFERENCES

Anfossi, A. (2017) The current state of recovery colleges in the UK.

Anthony, W.A. (1993) Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, 16, 11 –23.

Barton, S. and Williams, R. (2015, October). *Evaluation of ‘The Exchange’ (Barnsley Recovery College)*. Barnsley: South West Yorkshire Partnership Foundation Trust.

Bourne, P., Meddings, S. and Whittington, A. (forthcoming, accepted for publication). An evaluation of service use outcomes in a Recovery College. *Journal of Mental Health*.

Bristow, E. (2015). Recovery College Annual Report 2014/15. Lincolnshire Partnership NHS Foundation Trust.

Burhouse, A., Rowland, M., Niman, H.M., Abraham, D., Collins, E., Matthews, H., Denney, J. and Ryland, H. (2015). Coaching for recovery: a quality improvement project in mental healthcare. *BMJ Quality Improvement Reports*

Campbell-Orde, T., Chamberlin, J., Carpenter, J. et al (2005) *Measuring the Promise: A Compendium of Recovery Measures Vol II*. Human Services Research Institute Evaluation Center.



- Castelein, S., Bruggeman, R. J., van Busschbach, J. T., van der Gaag, M., Stant, A. D., Knegtering, H. & Wiersma, D. (2008) The effectiveness of peer support groups in psychosis: a randomized controlled trial. *Acta Psychiatrica Scandinavica*, **118**, 64-72.
- Central and North West London (2015) *Recovery and Wellbeing College Annual Report April 2014 to March 2015*. London: CNWL <http://www.cnwl.nhs.uk/wp-content/uploads/CNWL-Recovery-College-Annual-Report.pdf>
- CHIME – Laemy, M., Bird, V., Le Boutillier, C. et al (2011) Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *British Journal of Psychiatry*, **199**, 445-452
- Chung, R.E.; Curwood, S.E., Thang, H., Gruszecki, S., Beder, M. and Stergiopoulos, V. (2016). Introducing a Recovery Education Centre for Adults Experiencing Mental Health Challenges and Housing Instability in a Large Urban Setting. *International Journal Mental Health Addiction*, **14**, 850-855.
- Cook, J.A., Copeland, M.E., Jonikas, J.A., et al (2011) Results of a randomised controlled trial of mental illness self-management using wellness recovery action planning. *Schizophrenia Bulletin* doi: 10.1093/schbul/sbr012
- Daniels, S. and Edmonds, J. (2014). A Recovery College course for people with learning disabilities and mental health needs – early findings. Paper presented at the Learning Disability Research Group Seminar, 26 Nov 2014.
- Davidson, L., Bellamy, C., Guy, K. & Miller, R. (2012) Peer support among persons with severe mental illnesses: a review of evidence and experience. *World Psychiatry*, **11**, 123-128.
- Deegan, P. (1988) Recovery: The lived experience of rehabilitation, *Psychosocial Rehabilitation Journal*, **11**: 11-19.
- Department of Health (1999) *White Paper. Saving Lives: Our Healthier Nation*. London: DH
- Department of Health (2001) *The Expert Patient: A new approach to chronic disease management for the 21st century*. Department of Health: London
- Department of Health (2006) *Supporting people with long-term conditions to self-care: A guide to developing local strategies and good practice*. Department of Health: London
- Dunn, E.A., Chow, J., Meddings, S. & Haycock, L.J. (2016) Barriers to attendance at Recovery Colleges. *Mental Health and Social Inclusion*, **20**(4), 238-246.
- Foster, G., Taylor, S.J.C., Eldridge, S. Ramsey, J. & Griffiths, C.J. (2007) Self-management education programmes by lay leaders for people with chronic conditions. *Cochrane database of Systematic Reviews* Issue 4. Art. No.: CD005108.
- Frayne, E., Duke, J., Smith, H., Wayne, P. and Roberts, G. (2016). A voyage of discovery: setting up a Recovery College in a secure setting. *Mental Health and Social Inclusion*, **20** (1), 29-35.
- Gill, K. (2014). Recovery Colleges, co-production in action: the value of lived experience in 'learning and growth for mental health'. *Health Issues*, 10-14.
- Greenwood, K.E., Sweeney, A., Williams, S., et al (2010) Choice of Outcome In Cbt for psychoses (CHOICE): The development of a new service user-led outcome measure for CBT for Psychosis. *Schizophrenia Bulletin*, **36**(1), 126-135
- Hall, T., Brophy, L. and Jordan, H. (2016). A report on the early outcomes of the Mind Recovery College. University of Melbourne.
- Herth K. (1992). Abbreviated instrument to measure hope: development and psychometric evaluation. *Journal of Advanced Nursing*, **17**: 1251-9.
- Hewstone, M (2003) Intergroup contact: panacea for prejudice? *The Psychologist* **16**(7), 352-355
<https://cpr.bu.edu/living-well/services/health>
<http://mhead.slam.nhs.uk/disorders/dementia/mixed-dementia/mild/self-management/recovery-college/> and <http://www.cnwl.nhs.uk/recovery-college/>
- <https://riinternational.com/health/recovery-education-services/>
<http://www.cnwl.nhs.uk/recovery-college/>
http://www.cnwl.nhs.uk/wp-content/uploads/Recovery_College_Prospectus_2016-17.pdf
<http://www.cnwl.nhs.uk/recovery-college/>
<http://www.mungos.org/documents/7694/7694.pdf> where the Recovery Colleges offers therapy that may not be available elsewhere for homeless people.
<https://www.nottinghamshirehealthcare.nhs.uk/nottingham-recovery-college>
http://www.seslhd.health.nsw.gov.au/Recovery_College/
<http://www.slamrecoverycollege.co.uk/courses.html>
<http://www.swlstg-tr.nhs.uk/south-west-london-recovery-college>

- King, T. (2015). An Exploratory Study of Co-production in Recovery Colleges in the UK. Dissertation submitted in part-fulfilment of the University of Brighton degree MSc Mental Health.
- Kinn, A (2016) Reflections on the social model of distress or madness: how to make the social model of disability accessible to people with mental health challenges. *Mental Health and Social Inclusion*, 20(4), .231-237, <https://doi.org/10.1108/MHSI-06-2016-0018>
- McGregor, J. (2012) *It's not just education, it's about you*. Unpublished report, Nottinghamshire Healthcare NHS Trust, Duncan Macmillan House, Porchester Road, Nottingham, NG3 6AA, England.
- McGregor, J., Repper, J. and Brown, H. (2014), 'The College is so different from anything I have done'. A study of the characteristics of Nottingham Recovery College, *Journal of Mental Health Education Training and Practice*, 9(1) 3-15.
- Meddings, S, Campbell, E., Guglietti, S., Lambe, H., Locks, L., Byrne, D. and Whittington, A. (2015). From Service User to Student – The Benefits of Recovery College. *Clinical Psychology Forum*, 268, 32-37.
- Meddings, S., Byrne, D., Barnicoat, S., Campbell, E. and Locks, L. (2014). Co-Delivered and Co-Produced: Creating a Recovery College in Partnership. *Journal of Mental Health Training, Education and Practice*, 9, 16-25.
- Meddings, S., Guglietti, S., Lambe, H. and Byrne, D. (2014b). Student perspectives: Recovery College experience. *Mental Health and Social Inclusion*, 18, 142-150.
- Meddings, S., McGregor, J., Roeg, W. & Shepherd, G. (2015b). Recovery Colleges Quality and Outcomes. *Mental Health and Social Inclusion*, 19 (4), 212–221.
- Mezirow, J. (2000) *Learning as Transformation: critical perspectives on a theory in progress*. San Francisco: Jossey Bass
- Mid Essex Recovery College (2014). *Hope Health, Opportunity and Purpose for Everyone. Evaluation Report*. North Essex Partnership University NHS Foundation Trust, Trust Headquarters, 103 Stapleford Close, Stapleford House, Chelmsford, Essex, CM2 0QX, England.
- National Institute for Health and Clinical Excellence (2011) *Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services*, NICE clinical guideline 136 www.nice.org.uk/cg136
- National Voices (2014) Prioritising person-centred care: supporting self-management – summarising evidence from systematic reviews. http://www.nationalvoices.org.uk/sites/default/files/public/publications/supporting_self-management.pdf
- Neil, S.T., Kilbride, M., Pitt, L., Nothard, S., Welford, M., Sellwood, W., Morrison, A.P., 2009. The Questionnaire about the Process of Recovery (QPR): a measurement tool developed in collaboration with service users. *Psychosis. Psychological, Social and Integrative Approaches*, 1(2), 145–155
- Newman-Taylor, K., Stone, N., Valentine, P., Hooks, Z. and Sault, K. (2016). The Recovery College: a unique service approach and qualitative evaluation. *Psychiatric Rehabilitation Journal*, 39 (2), 187-190.
- North Essex Research Network with South Essex Service User Research Group (2014). *Evaluation of the Mid Essex Recovery College October-December 2013*. Anglia Ruskin University. Available at: <http://hdl.handle.net/10540/347125>. (Accessed 10 February 2015).
- Nurser, K., Hunt, D., & Bartlett, T. (forthcoming). Do Recovery College courses help to improve recovery outcomes and reduce self-stigma for individuals who attend? *Clinical Psychology Forum*.
- Perkins, A., Ridler, J., Hammond, L., Davis, S. Hackmann, C. (2017) Impacts of attending Recovery Colleges on NHS staff. *Mental Health and Social Inclusion*, 21(1), 18-24.
- Perkins, R. (2012) UK Mental Health Policy Development: A counter-argument deriving from users' experiences, Chapter 2 in Phillips, P., Sandford, T. & Johnston, C. (eds.) *Working in Mental Health: Practice and Policy in a Changing Environment*. Oxford: Routledge.
- Perkins, R. (2015) Recovery: A journey of the mind and spirit, *Clinical Psychology Forum Special Issue: Recovery*, 268 (April), 38-43
- Perkins, R. and Repper, J. (2017) When is a Recovery College not a Recovery College, *Mental Health and Social Inclusion*, 21(2) 65-72.
- Perkins, R., Repper, J., Rinaldi, M. and Brown, H. (2012) *Recovery Colleges*. ImROC Briefing Paper, Nottingham: ImROC <https://imroc.org/resources/1-recovery-Colleges/>
- Priebe S, Huxley P, Knight S, Evans S. (1999) Application and results of the Manchester Short Assessment of quality of life. *International Journal of Social Psychiatry*, 45:7-12.



- Recovery in the Bin (2017), "Stepford Recovery College: where alternative facts are not just for Americans", available at: <https://recoveryinthebin.org/2017/02/03/stepford-recovery-College> (accessed 6 February 2017).
- Rennison, J., Skinner, S. and Bailey A. (2014). *CNWL Recovery College Annual Report*. Central and North West London NHS Foundation, 2nd Floor, Stephenson House, 75 Hampstead Road, London, NW1 2PL.
- Repper, J. & Carter, T. (2011) A review of the literature on peer support in mental health services. *Journal of Mental Health*, **20**, 392-411
- Repper, J. & Perkins, R. (2012) Recovery: A journey of Discovery for Individuals and Services, Chapter 7 in Phillips, P., Sandford, T. & Johnston, C. (eds.) *Working in Mental Health: Practice and Policy in a Changing Environment*. Oxford: Routledge.
- Repper, J. & Perkins, R. (2003) *Recovery and Social Inclusion*. London: Balliere Tindall.
- Repper, J. (2013) *Peer Support Workers: Theory and Practice*. Nottingham: ImROC <https://imroc.org/resources/5-peer-support-workers-theory-practice/>
- Rinaldi, M. (2002) Manic depression and self-management. In Ramsey, R., Page, A., Goodman, T and Hart, D. (Eds) *Changing Minds: Our Lives and Mental Illness*. London: Gaskell
- Rinaldi, M. and Suleman, S. (2012). *Care co-ordinators attitudes to self-management and their experience of the use of South West London Recovery College*. South West London and St. Georges Mental Health NHS Trust, Building 15, Springfield University Hospital, 61 Glenburnie Road, London, SW17 7DJ.
- Rinaldi, M. and Wybourn, S. (2011). *The Recovery College Pilot in Merton and Sutton: longer term individual and service level outcomes*. South West London and St. Georges Mental Health NHS Trust, Building 15, Springfield University Hospital, 61 Glenburnie Road, London, SW17 7DJ.
- Shepherd, G. (2015). Possible mechanisms of change in Recovery Colleges – individual and organisational. Paper presented at the Recovery Colleges International Community of Practice, 5 June, 2015.
- Shepherd, G., Boardman, J., Rinaldi, M. and Roberts, G. (2014). *Supporting Recovery in Mental Health Services: Quality and Outcomes. ImROC Briefing Paper 8*. Centre for Mental Health (online). Available at: http://www.centreformentalhealth.org.uk/pdfs/ImROC_briefing8_quality_and_outcomes.pdf (Accessed 16 March 2015)
- Skinner, S. and Bailey (2015). *CNWL Recovery and Wellbeing College Annual Report April 2014-July 2015*. Central and North West London NHS Foundation, 2nd Floor, Stephenson House, 75 Hampstead Road, London, NW1 2PL.
- Solent Recovery College Management Group (2014). *Solent Recovery College: our first year – outcomes*. Portsmouth: Solent Recovery College.
- Sommer, J. (2017) *South Eastern Sydney Recovery College Preliminary Evaluation Report: the first three years 2014-2017*, South Eastern Sydney Local Health District, Sydney, Australia.
- Sommer, J., Gill, K. and Stein-Parbury, J. (2017) Walking side-by-side: Recovery Colleges Revolutionising Mental Health Care, submitted to *Journal of Mental Health Training Education and Practice*
- Stone, N., Rose, J., Valentine, P., Newman-Taylor, K, Hooks, Z., Crick, D. & Sault, K. (2014). *Southern Health Recovery College Service Evaluation 2013-14*. Southern Health.
- Tingey, T. Gilfoyle, S. (2015). Recovery College East - The journey so far: January 2013-2015 . Biennial Report 2015, Cambridge and Peterborough Foundation Trust. Unpublished.
- Watson, E. (2013). What Makes a Recovery College? A Systematic Literature Review of Recovery Education in Mental Health. University of Nottingham: MSc Health and Social Care Dissertation.
- Walters, P. (2015) Creative minds: developing supportive creative opportunities in our communities". *Mental Health and Social Inclusion*, **19** (1), 30-37. <https://doi.org/10.1108/MHSI-12-2014-0041>
- Zabel, E., Donegan, G., Lawrence, K. and French, P. (2016). Exploring the impact of the recovery academy: a qualitative study of Recovery College experiences. *Journal of Mental Health Training, Education and Practice*, **11** (3), 162-171.
- Zucchelli, F.A. and Skinner, S. (2013) Central and North West London NHS Foundation Trust's Recovery College: the story so far. *Mental Health and Social Inclusion*, **17**, 183-189.

ImROC's Vision

For systems, services and cultures to support Recovery and wellbeing for all locally, nationally and internationally.

ImROC's Mission

ImROC works in partnership with communities to develop systems, services and cultures that support recovery and wellbeing for all. ImROC has been leading the way in recovery-oriented service and practice improvement since 2011.

Originally established on behalf of the Department of Health to champion its 'Supporting Recovery' initiative, through a collaboration between the Centre for Mental Health and the NHS Confederation's Mental Health Network, ImROC is now hosted through Nottinghamshire Healthcare NHS Foundation Trust. This innovative new partnership allows us to cement our close working relationship with frontline providers of care, ensuring that our work remains relevant and useful to practitioners, managers, system leaders, local communities and ultimately, the people who access services.

Our role is about enabling people (who use services, work in services and live in communities) to unlock and pool the strengths and talents they take for granted, explore new ways to make use of them, share knowledge and learning, and facilitate recovery-oriented improvement in the outcomes and experience of health and social care. We rely on and embrace the expertise, experience and collective wisdom of everyone we work with, and encourage communities to develop as a result. Our job is about using our expert knowledge to inspire others to believe that change is possible; pursue their dreams, and most importantly to act: changing attitudes and behaviours. This ethos of working in co-production is at the heart of our organisational work, and role models what we seek to achieve at a practice level too.

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