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. http://www.bps.org.uk/networks-and-communities/member-microsite/division-clinical-psychology/clinical-psychology-forum

From Service User to Student – The Benefits of Recovery College

Sara Meddings, Emogen Campbell, Shannon Guglietti, Hazel Lambe, Lucy Locks, Diana Byrne and Adrian Whittington

Recovery Colleges offer an educational non-stigmatising approach to recovery from serious mental health challenges. We are a group comprising a student, a peer trainer and some of the professional staff involved with two Recovery College pilots. Here we report on an evaluation of these pilots in terms of student outcomes, uptake of courses and resource use. Results suggest that Recovery Colleges can contribute powerfully and efficiently to recovery and wellbeing.

Introduction

I would highly recommend the Recovery College to others, especially anyone on a personal journey towards more positive health and well-being. Student

People using mental health services have long requested more information, support for self-directed care and self-management, empowerment and choice and employment of peers in providing services (e.g. Social Care Institute for Excellence, 2007). This has driven the development of recovery oriented practice in mental health services over the past 20 years. Recovery orientation requires a focus on approaches which foster hope and the possibility of reaching personal goals and ambitions; taking back control of symptoms and life; developing valued roles and relationships; finding meaning and purpose, and having the opportunity to do what is personally valued to build a life beyond illness.

Cultural change in mental health services towards recovery oriented practice is supported by mental health policy. *No Health without Mental Health* sets the objective that 'more people with mental health problems will recover' by having 'a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live.' (Department of Health, 2012, page 6). NHS Confederation (e.g. 2012, 2014), NICE (e.g. 2014), and Kings Fund (e.g. Goodwin etal, 2010) also recommend recovery practice and assert that top priorities for mental health services include supporting self-management, educating people about their conditions and expanding the peer workforce (workers with expertise by personal experience of mental health challenges).

At the same time as the push for cultural change there are pressures on services to increase productivity, deliver efficiently and meet increasing demand, whilst

challenged by diminished resources (NHS Confederation, 2014). Introducing group-based alternatives to individual interventions in mental health services is one way in which this might be achieved. Interventions that connect service users with others with similar experiences can have additional advantages when they enable people to learn coping strategies, develop relationship skills, reduce isolation and gain hope (Corey et al., 2013).

Recovery Colleges are a relatively new approach to serving the needs of people with serious mental health challenges within an educational, rather than therapeutic model. Service users become students and undertake courses designed to empower people to manage their own recovery. All aspects of the College and its courses are co-designed and co-produced by experts by personal experience of mental health challenges alongside experts by professional training. They are strengths based and person-centred; inclusive for people with mental health challenges, their relatives / carers and staff; mental health recovery oriented; and progressive, helping people reach their own goals (Perkins et al., 2012; McGregor et al., 2014).

Students choose what courses they want to go on from a prospectus. Personal tutors offer information, advice and guidance; develop individual learning plans based on students' hopes and aspirations, and identify learning support needs. Following course attendance, students graduate with certificates of success. Courses aim to support students to develop their own resilience, follow their aspirations and become experts in their own care.

Recovery Colleges have been well received, with positive feedback about the process of co-production of the college itself as well as about courses (Meddings et al, 2014). After attending, students feel more hopeful about the future; more able to achieve their goals; have their own recovery plans; more friendships and work opportunities; and use mental health services less (Rinaldi and Wybourn, 2011). Recovery college 'provides a catalyst for change and even transformation through an educational orientation …It enables them [students] to re-define their personal experience of mental health issues, (re)create an identity beyond illness and explore new social networks and supports' (McGregor et al., 2014, p.13) Students value learning from each-other; co-production approach and lived experience; learning new skills and knowledge; choice and progression to personal goals (Meddings et al, in preparation). These findings are based on initial audits – there is a need for robust outcome evaluation and research.

This paper describes an evaluation of Sussex Recovery College, highlighting student outcomes and potential efficiencies of the recovery college model.

Background – Sussex Recovery College

Sussex is a large county on the South East coast with a population of 1.6 million. Two pilot recovery colleges were created in 2013 in Brighton and Hastings by a partnership of Brighton and Hove Mind, Activ8 (Hastings and Rother Mind) and Sussex Partnership NHS Foundation Trust. Both pilots were based in relatively deprived urban areas with affluent surrounding areas. The development of the

college is discussed in our case study of the co-production of Hastings campus (Meddings, et. al. 2014).

The majority of students were people with mental health challenges: 60% were using secondary mental health services and 18% primary care; 8% were relatives or carers (11% including carers with mental health challenges) and 16% were staff. The majority identified as female (66%); white British (86%); and heterosexual (85%); there was a spread of ages from early 20s to late 80s with 76% aged 25-54. Of those using mental health services, PbR clusters showed 62% had anxiety or depression, 37% psychosis and 1% dementia. The average HoNOS score was 11.9.

Method

We evaluated the two Recovery College pilots using self-reported student outcomes: personal recovery goal attainment, learning outcome attainment, wellbeing and quality of life. In one site we also measured uptake and resource use. The methodology, including overall aims and choice of measures, was co-produced by a team of potential students, peer trainers and mental health professionals.

Procedure
A pragmatic sample of students who had been offered places on courses were asked to take part in the evaluation (those who registered on the days the interviewer was present on site). Students were approached by telephone when they were invited for their Individual Learning Planning meeting (ILP). Students were supported to complete outcome measures before attending their first course (pre) and after the end of their final course (post) at the end of term.

Participants
Seventy percent of those asked agreed to take part in the pre/post evaluation. Thirty-five students completed both pre and post interviews. The participants were representative of students as a whole in terms of age, gender, sexual orientation, ethnicity, religion and disability. We interviewed mainly students with mental health challenges, who were prioritised for ILPs - staff and carers were under-represented. More students from Hastings than Brighton took part in the evaluation.

Measures
Self-report measures were used including bespoke measures designed for the pilot and standardised questionnaires:

Personal Goals – recovery is a unique and individual process. The team thought that the most important measure was whether or not students made progress towards their own personal goals. Students were asked to prioritise their three most important goals in life and rate them on a Likert scale (from 1-7).

Course Learning Outcomes – trainers provided three main learning outcomes for the courses they co-produced. Students were asked to rate themselves in relation to each of these for each of the courses they attended (up to three) on a Likert scale (1-7).

Standardised Questionnaires
Process of Recovery Questionnaire (Neil et al 2009) – measure of personal recovery, constructed with service users (including hope, control and opportunity) (0-88).

Manchester Short Assessment of Quality of Life (MANSA) (Priebe et al 1999) – measure of quality of life (1-7).

CHOICE short form (adapted from Greenwood, 2010) – service user-led measure assessing psychological recovery and mental health (0-11).

Warwick and Edinburgh Mental Wellbeing Scale (short form) (SWEMWBS) (Tennant et al 2007) – measure of general wellbeing and psychological distress (7-35).

Objective measures of socially valued goals
Students were asked about employment status; whether they were students outside the college; and how many friends they had who they could talk to about mental health and recovery.

Demographic information was collected through college registration forms.

Analysis
Descriptive statistics were computed. Statistical comparisons of measures before and after attending the college were made using two tailed non-parametric tests. Wilcoxon signed-rank test was used to analyse all measures except the categorical socially valued goals where McNemar Chi Squared test was used. Quotes are taken from course feedback forms to illustrate the findings in students' own words.

Results

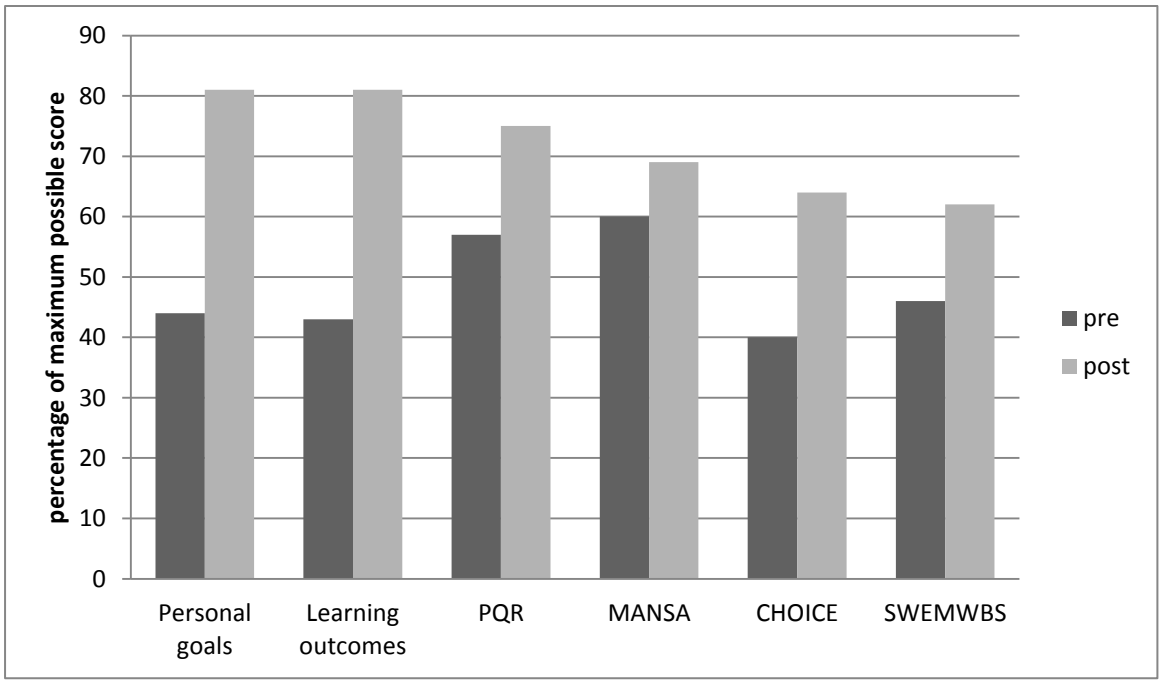
Student Outcomes
There was a high level of student satisfaction, with 97% reporting that they would recommend the course they had completed. Students commented on feedback forms:

- *I feel more able to control my own recovery*
- *It was helpful to learn techniques that help me manage my anxiety*
- *I also made so many friends. I feel included, not alone*
- *Improved self-esteem and confidence*
- *The course was useful, informative and easy to follow. It taught me CBT that I could understand. I was able to increase my management skills. It put me in the driving seat. It improved my sleep, and my feelings around sleep. I've been able to do more in the day.*

Students made significant progress whilst attending courses at the Recovery College. The three most commonly cited personal recovery goals were 'gain confidence', 'increase knowledge and/or skills' and 'meet other people'. There were large pre-post effects observed on all student self-reported outcomes (see Table 1).

Table 1: Mean, Standard Deviation (SD), Z score, *p* score and effect size for each measure and N.

	Mean (SD)		Z	*p*	Effect size	N
	Pre	Post				
Personal Goals	3.1 (1.0)	5.7 (0.9)	-5.16	<.01	0.83	35
Course Learning Outcomes	3.0 (1.0)	5.7 (0.8)	-4.85	<.01	0.85	31
Personal Recovery (PQR)	50.2 (15.6)	65.9 (11.4)	-3.96	<.01	0.75	32
Quality of Life (MANSA)	4.2 (1.0)	4.8 (0.9)	-3.76	<.01	0.83	29
Psychological Recovery and Mental Health (CHOICE)	4 (1.7)	6.4 (1.4)	-4.46	<.01	0.86	27
Wellbeing and Psychological Distress (SWEMWBS)	20.0 (4.9)	24.3 (3.6)	-4.06	<.01	0.78	27



We worked out individual reliable change for the CHOICE - 63% students showed individual reliable improvement (1.45+). All but one of the others showed some improvement – no one changed reliably for the worse.

In terms of socially valued goals, no significant differences were found for paid employment (p=0.63), voluntary employment (p=1.00) or becoming a student (p=1.00). There was a significant increase in the number of friends students felt like they could talk to about mental health and recovery (p<.05, Z=-2.432, effect size=0.45).

Uptake and Resource Use

The Recovery College has been popular. During the pilots over 300 students registered. The most popular courses were:

- Happiness
- Mindfulness
- Using the Arts to Aid Recovery;
- Coping with Depression/Anxiety;
- Coping Strategies and Problem Solving;
- Improving your Sleep (CBT)
- Understanding a Diagnosis (and formulation) of Psychosis/Mood Disorders.

We worked out resource use for one pilot (Hastings). There were 29 courses with an average number of 11 enrolled students; 319 course places were offered and 214 attended. Attendance rates of 67% were within typical levels for mainstream adult education. In total 1069 taught sessions were attended.

Including ILPs, planning and supervision, the total staff time per course (for two tutors) was 56 hours and face to face student hours was 85 hours: a ratio of 5:9. Five hours staff time produced nine hours student contact. Enrolment and graduation increased both staff time and student contact.

Discussion

High levels of student satisfaction were achieved and large gains were apparent in student self-report measures: attaining personal goals, achieving course learning outcomes, personal recovery (PQR), psychological recovery and mental health (CHOICE), wellbeing (SWEMWBS) and quality of life (MANSA). The evaluation indicates that uptake and resource use compares favourably with individual interventions and could offer an efficient alternative form of provision to some aspects of existing mental health services.

Audits of other Recovery Colleges show increased progression to work and mainstream college (Rinaldi and Wybourn, 2011). Similar impact was not demonstrated during the pilot, although this would perhaps be more meaningful to measure at a later follow-up.

The qualitative feedback from students suggests a powerful impact of the college and potential for it to transform traditional dynamics between mental health service

users and providers. The personal account of one of us (HL), a student who took part in the evaluation, illustrates this:

> *The prospectus outlines opportunities for learning and puts you in control. You choose what might help you. That is empowering. At an individual learning planning meeting you are welcomed and supported by a peer, to focus on personal goals, and knowledge and skills to be gained. Filling in a series of questionnaires for the RC Evaluation could have been a daunting task, but our staff were so positive that it became fun, and relevant. I achieved my goals of improving social skills and confidence. The course learning outcomes measures helped me to chart my progress. I was surprised, and pleased to see how much I had learned. Peer experience ensures a deeply empathic feel to learning, helping professional research theory come alive. Experience from fellow students creates an extra supportive dimension and opportunity for friendships to develop. The graduation is a special occasion which marks group and personal achievement and success. Now I am proud to be a student representative, I am applying to train and work in peer support and have been discharged from mental health services.*

Routine outcome measurement is recommended. A randomised controlled trial of Recovery College is needed to assess efficacy. Follow-up studies could determine whether changes are maintained over time, the longer-term impact on service use and progression to employment and mainstream education. Systematic qualitative studies could explore core characteristics of Recovery College and whether key effective components for example are the employment of peers, co-production, students taking control of their recovery or the courses themselves. Recovery College students choose what they think will work for them – this raises a research question about whether service users are as good as mental health professionals at assessing or deciding what particular treatments or interventions might help them most.

Recovery College offers one solution to providing interventions for mental health challenges efficiently, enabling services to reach more people than could be helped by individual interventions within the same resources. Recovery educational approaches need to be integrated with other aspects of mental health services so that progress made by students can be optimised. Mental health teams can support students whilst they are at college, then with further progression after graduation – including thinking with them about employment, further education and discharge from services.

Recovery Colleges combine the expertise of mental health professionals and peers with lived expertise in an educational context where students take control of their own recovery. They are a promising new approach to mental health with much scope for further development.

Postscript

Hazel is now working for a Housing Association and as a peer support worker in the NHS

Authors

All authors are from Sussex Recovery College and/or Sussex Partnership NHS Foundation Trust. www.sussexrecoverycollege.org.uk

Sara Meddings: Psychology and Psychological Therapies Lead for Recovery and Wellbeing sara.meddings@sussexpartnership.nhs.uk.

Emogen Campbell: Assistant Psychologist

Shannon Guglietti: Assistant Psychologist

Hazel Lambe: Student Representative; lived experience of mental health challenges.

Lucy Locks: Deputy Director of Occupational Therapy

Diana Byrne: Senior Peer Recovery Trainer; activist; diagnosed with Bi-polar disorder.

Adrian Whittington: Director of Education and Training

Acknowledgements
All the students who took part in the evaluation; Su Barnicoat, Jo Wren, Caroline Donovan, Kate Webb, Phyllis Clifford, Karen Swain from the evaluation sub-group; Ruth Chandler, LEAF and Kathy Greenwood for research advice.

References

Corey, S., Corey, G. & Corey, C. (2013). *Groups Process and Practice*. Belmont CA: Cengage Learning.

Department of Health (2012). *No Health without Mental Health.* London: HM Government.

Greenwood KE, Sweeney A, Williams S, Garety P, Kuipers E, Scott J, Peters E. (2010). CHoice of Outcome In Cbt for psychosEs (CHOICE): The Development of a New Service-User led Outcome Measure of CBT for Psychosis. *Schizophrenia Bulletin*, **36**(1) 126-135.

Goodwin, N., Curry, N., Naylor, C., Ross, S. & Duldig, W. (2010). *Managing People with Long-term Conditions*. London: The Kings Fund.

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., Byrne, D., Barnicoat, S., Campbell, E. & Locks, L. (2014). Co-Delivered and Co–Produced: Creating a Recovery College in Partnership. *Journal of Mental Health Training, Education and Practice*, **9**(1), 16-25.

Meddings, S., Guglietti, S., Lambe, H. & Byrne, D. (2014). Student perspectives: recovery college experience. *Mental Health and Social Inclusion,* **18**(3), 142-150.

Neil, S.T., Kilbride, M., Pitt, L., Nothard, S., Welford, W., Sellwood, W., Morrison, A.P. (2009) The questionnaire about the process of recovery (QPR): A measurement tool developed in collaboration with service users. *Psychosis,* **1**, 145-155.

NICE (2014). *Psychosis and schizophrenia in adults: treatment and management: NICE clinical guideline 178*. London: NICE.

NHS Confederation/Centre for Mental Health (2012). *Supporting Recovery in Mental Health*, Briefing paper 244. London: NHS Confederation.

NHS Confederation (2014). *The Future of Mental Health*. Discussion Paper, issue 16. London: NHS Confederation.

Perkins, R., Repper, J., Rinaldi, M. and Brown, H. (2012). *Recovery Colleges*. ImROC, NHS Confederation, Centre for Mental Health.

Priebe, S., Huxley, P., Knight, S. & Evans, S. (1999). Application and results of the Manchester short assessment of quality of life (MANSA). *International Journal of Social Psychiatry*, **45**, 7-12.

Rinaldi, M. and Wybourn, S. (2011). The Recovery College Pilot in Merton and Sutton: longer term individual and service level outcomes. SW London and St Georges NHS Trust.

Social Care Institute for Excellence (SCIE), CSIP & RCPSYCH (2007). *A Common Purpose: Recovery in future mental health services*. London: SCIE.

Tennant, R., Hiller, L., Fishwick, R., Platt, P., Joseph, S., Weich, S., Parkinson, J., Secker, J., Stewart-Brown, S. (2007). The Warwick-Edinburgh Mental Well-being Scale (WEMWBS): development and UK validation, *Health and Quality of Life Outcomes,* **5**(63).