Editorial

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When is a "recovery college" not a "recovery college"?

It is rare that an idea has been taken up so widely, or so quickly, in the mental health arena as that of a "recovery college". The first UK recovery college was established in 2010 in South West London based on a pilot study conducted in 2009. Now there are well over 40 recovery colleges across the UK and elsewhere in the world: from Australia to Japan and Singapore. They have proved hugely popular among those who use them: indeed many colleges struggle to keep up with demand.

The idea of "recovery education" predated these initiatives. In the UK, the Expert Patient Programmes have existed for some 15 years. These adopt an educational paradigm for helping people to manage long-term health conditions – including mental health challenges (Department of Health, 2001, 2006). While people with lived experience are involved in co-facilitating these programmes, the content is largely prescribed by professionals. They are aimed only at those with long-term health conditions and they focus on symptom management rather than the broader issues of rebuilding a life.

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"[1]. In the Recovery Education Centre in Phoenix, Arizona, "trained peer facilitators help individuals develop skills and tools that can lead to success in all aspects of wellness and daily living"[2]. However, both of these are quite different 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 recovery focussed education but do not bring together the expertise of lived experience and professional expertise in a process of co-production and co-learning (professionals, people with mental health challenges, those who are close to them learning together). They are based on a didactic model of learning rather than a more democratic learning environment in which the expertise of all is valued and shared. They offer a discreet number of courses that are mainly manualised and run over a number of weeks rather than a wide range of courses varying from an hour long to full accredited courses.

Recovery colleges, while learning from these recovery education initiatives, represent a departure in terms of models and approach. They are intended to offer a comprehensive range of courses based on the wishes and needs of those who use them and form a core part of mental services. They involve 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. Based on the theory and values that lay behind the development of the first UK recovery colleges in South West London[3], Nottingham[4] and Central and North West London[5] a briefing paper outlining a series of eight key principles of a recovery college was produced by ImROC in 2012 (Perkins *et al.*, 2012). The aim was not to prescribe what people should do, but rather to offer a framework for creativity.

It is undoubtedly the case that such creativity has occurred, some of which has been documented in the pages of *Mental Health and Social Inclusion* (see McCaig *et al.*, 2014; Meddings *et al.*, 2014, 2015; Frayn *et al.*, 2016; Dunn *et al.*, 2016; Perkins *et al.*, 2017). In the light of their experience, the Nottingham Recovery College has developed a set of "critical dimensions" for success of recovery colleges within the eight key principles (McGregor *et al.*, 2014, pp. 8-11):

- "Educational. The development and provision of recovery-focused knowledge/ understanding, coping strategies, skills and application of learning is facilitated through a recovery-focused curriculum".

- "Collaborative. Lived, life, professional and subject expertise and experience are brought together in co-production, co-facilitation and co-learning".
- "Strengths based and person-centred. For all students and staff, achievements, strengths, skills and qualities are identified, built upon and rewarded. Adjustments and supports are put in to overcome challenges".
- "Progressive. Students work towards goals, and/or to overcome personal challenges. Courses and support are agreed through an ILP [individual learning plan] which is regularly reviewed".
- "Community focused. The college is community facing with active engagement with community organisations and FE colleges to co-produce relevant courses and facilitate pathways into valued roles, relationships and activities".
- "Inclusive. The college offers learning opportunities to students of all abilities, cultures, ages and experiences. A sound differentiation policy ensures that everyone has equal access to learning and the contribution that everyone can make is recognised and valued".

However, as different models and approaches emerge, the question must also be asked "when is a Recovery College not a Recovery College"? When does a deviation from the initial principles mean that a service is no longer a genuine recovery college? This is important because recovery colleges have not been without their critics, most candidly described by Recovery in the Bin (2015, 2017). Many of the criticisms result from misunderstandings of, and departures from, the original eight principles (Perkins *et al.*, 2012) and critical dimensions for success (McGregor *et al.*, 2014). The time would appear to be right to "go back to first principles", take seriously the criticisms levelled at recovery colleges, and examine what we do in the light of these.

Principles and practice

> Principle 1: co-production between people with personal and professional experience of mental health problems (Perkins *et al.*, 2012, p. 3).

Recovery colleges should be founded on co-production and co-delivery: bringing together the expertise of lived experience and professional expertise at every level and every stage from initial planning and development to decisions about operation, curriculum and quality assurance. As well as the expertise of lived experience from peer trainers, this co-production should involve not only the expertise of mental health professional trainers, but also relevant experts from outside the mental health arena (e.g. debt advisors, housing providers and welfare benefits experts). However, it is not assumed that all expertise rests with course designers and facilitators; it also rests with the learners in the room. "We learn from each other and we inspire each other" (Perkins *et al.*, 2012, p. 4). Co-production is an ongoing iterative process involving both peer and professional facilitators and students.

While many recovery colleges adhere to the principles of co-production at all levels, others do not. Some have incorporated courses written by mental health workers and then delivered by peer and professional trainers. This can readily lead to nothing more than tokenistic "involvement of people using services within a framework and agenda set by professionals:

> Learn the art of quashing service user dissent […] service users who would like to obtain advanced skills in "sit down and shut the fuck up" […]. Only biddable Mentals need apply. Mentals who think and ask questions don't have sufficient INSIGHT for Recovery College (Recovery in the Bin, 2017, p. 4).

On the other hand, in efforts to redress the balance between professional and peer expertise, some colleges have been largely developed and delivered by peers. While the expertise of lived experience is important, many people also value understanding (if not agreeing with) the expertise of professionals and the research evidence. This means that colleges may be accused of not being "evidence based", and, indeed a cheap alternative designed to cut costs:

> The "curriculum is brought to you with a total lack of evidence base – in the age of austerity we no longer need an evidence base, we just need to cut costs and get you pesky Mentals off our books.

> We can guarantee a 100% success rate – as long as you don't ask to see the RCTs [randomised, controlled research trials]" (Recovery in the Bin, 2017, p. 2).

The essence of a recovery college, as originally conceived, is bringing together the expertise of lived and professional experience – the "evidence base" of both professionals and peers – making both available to learners, and, where there are differences and disagreements, presenting both and leaving students to decide what makes sense to them. The absence of either professional or peer expertise denudes the college of vital expertise.

Another accusation is that some of the supposed "equality" in colleges is illusory. While professional trainers are paid at professional rates, peer trainers are either paid at lower rates, or sessional rates on "zero hours contracts", or act as unpaid volunteers – to borrow the words of George Orwell (1945) "all animals are equal, but some animals are more equal than others":

> Earn less than your professional colleagues (but it's better than zero hrs in a supermarket) […] because you might be equal […] but no matter how "recovered" we say you are, you are still mental and will never be worth as much to the college as us (Recovery in the Bin, 2017, p. 4).

In the original recovery colleges, the job descriptions and grading for peer and professional trainers was the same. However, under pressure from NHS pay structures, in some places this has been eroded with peer trainers being paid at lower rates than trainers who are mental health professionals. While most recovery colleges employ some peer trainers on substantive contracts with the same terms and conditions as anyone else, many have peer trainers who work on a sessional basis. This is similar to the many sessional trainers who work in community colleges, and may be useful for some people who do not want full time work. Others may work on a volunteer basis.

Both of these may be important to allow people to contribute, and earn some money, without jeopardising their benefits. However, it is important to be continually mindful of the very real risk of exploitation. The aim of a recovery college is not to provide a service "on the cheap" but to provide enhanced opportunities for growth and development where people can access both lived and professional expertise:

> Principle 2: There is a physical base (building) with classrooms and a library/computers where people can do their own research. A physical base is a tangible representation of commitment to the model (Perkins *et al.*, 2012, p. 4).

The physical base may be on a "hub" with "spokes", but without it colleges become intangible places that people cannot visit and explore what is on offer. "Virtual" colleges lack a clear identity that makes it hard for them to be a core part of services – even the open university has a physical base. The absence of a physical base also makes it hard to provide people with a recovery library (with materials selected by people with lived and learned experience), and internet access, where people can do their own research. The aim of such libraries is not to replace local libraries, but to specifically make available to all professional and peer literature and recovery resources that are often lacking in public libraries.

If people do not have access to the literature, resources and computers they need to do their own research then they are dependent on the facilitators to provide all information. This lays recovery colleges open to criticism of being prescriptive and offering only a service-based "truth":

> We provide the classroom, set the schedule, define the time limits – all you need to do is comply […] Our fast-paced, shallow and fully self-contained courses have been designed to leave no need for further reading, questioning or dissent (Recovery in the Bin, 2017, p. 2).

While some recovery colleges offer library and internet access, many do not. The provision of facilities for people to do their own research is especially critical in a mental health setting where many people are living in poverty.

One of the innovations in this area is the approach adopted by the Western Health and Social Care Trust in Northern Ireland. In this largely rural area a partnership has been formed with the library service. This provides local accessible "spokes" for the recovery college in local libraries and the libraries provide resources for people to do their own research independent of the

recovery college: they have been keen to acquire mental health and recovery materials within their mainstream library collections to facilitate this:

> Principle 3: It operates on college principles (Perkins *et al.*, 2012, p. 5).

A recovery college is not a day centre. It involves a different kind of relationship between professionals and people using services: from a patient or client to a student or tutor, from a therapist to a student or tutor who makes available their expertise to those who might be interested. It does not provide care management or risk assessment. People are not referred to a college on the basis of a professional judgement about what might be good for them, they choose courses from a prospectus and register for the ones that interest them. There is no selection based on diagnosis or clinical condition.

While some recovery colleges stick to college principles, in an era where resources are scarce it is tempting for colleges to try to make up for perceived shortcomings in other areas: offering outreach support, counselling, support in day to day activities, etc. There may also be pressure for colleges to take on "care management" responsibilities and offer recreational activities and therapeutic possibilities that people lack elsewhere. Such tendencies may be understandable, but they also destroy the unique relationships and transformation from therapy to education that is the hallmark of a recovery college:

> Principle 4: It is for everyone (Perkins *et al.*, 2012, p. 5).

A recovery college is founded not only on the principle of co-production and co-delivery, but also of co-learning.

There is a grave risk of a recovery college becoming yet another mental health ghetto that traps those experiencing mental health challenges and increases their marginalisation in a parallel universe:

> Your Future Starts Here! We've made a college just for Mentals: prepare to be patronised! You can pretend you are going to college just like the Normals! (Recovery in the Bin, 2017, p. 2).

Ensuring co-learning involves a number of dimensions.

First, if we really value the expertise of lived experience on a par with professional experience then professionals have something to learn from people with lived experience and vice versa. This means that it is important for people with lived experience and the staff who provide services to come together in an inclusive learning environment where people can learn from each other. Perkins *et al.* (2017) have researched the experience of staff attending a recovery college and all found it to be a positive experience. For example, the majority said that it had eroded the barriers between clinicians and service users and thereby challenged their views, enabled them to reflect on what "recovery" means, increased their understanding, empathy and skills and challenged non-recovery practices. In total, 63 per cent also said that it had a positive impact on their personal well-being.

While some recovery colleges, like that in Norfolk and Suffolk[6], have successfully attracted many professionally qualified and non-professionally qualified students to learn alongside people who use the service, this has not universally been the case. Some have no staff attendees, and others have very few. This is problematic because it conveys the message that staff having nothing to learn about the lived experience of mental health challenges and recovery from those with lived experience who use the service. This serves to reinforce traditional "them" and "us" boundaries.

Second, the world of people with mental health challenges does not lie wholly within the mental health service. Recovery may be a personal journey but it is not a journey travelled alone. It is one travelled in the context of friends and family – who may both benefit from attending the recovery college. It is also one travelled in the context of a culture and society that erects many barriers to recovering a life with mental health problems. By learning alongside people with lived experience of mental health challenges both others who are close to the person, and health and social care staff, can gain a valuable understanding of the realities of recovery and how people have managed to navigate their way through the many barriers they face.

Finally, there are many people with mental health and related challenges who are not receiving help from mental health services who could benefit from attending the recovery college. In addition, some people wish to continue to use the recovery college when they are discharged from services. There are also people with long-term physical health conditions who face the challenge of recovering a life. Recovery colleges are in an ideal position to bring together people with a range of mental health and related challenges and provide a service to a broader community.

Sometimes as a result of funding restrictions, recovery colleges are not able to provide a service outside secondary mental health services. While this remains the case, the risk of simply creating another ghetto remains high. However some colleges, like Nottingham, Central and North West London and Dorset[7] have been creative in negotiating contracts to serve people in primary care and those with a broader range of challenges thus creating a setting in which people can learn together and benefit from each other's experience:

> Principle 5: There is a Personal Tutor (or equivalent) who offers information, advice and guidance.

It is not uncommon for mainstream colleges to provide some form of personal tutor or admissions tutor to provide people with guidance and support to choose courses appropriate to their needs and aspirations. The same applies to a recovery college: people often value discussing which courses might be suitable for them and helping them to draw up an individual learning plan to achieve their personal goals. Such a tutor can also help allay people's fears and anxieties, ascertain their access needs and thus be valuable in making the college accessible to a broader range of people who may be less confident:

> The tutor made me realise I could do it. Helped me to work out what courses might help me to achieve my goals (Perkins *et al.*, 2012).

An increasing number of colleges are recognising the importance of a personal tutor and individual learning plans, however, it is important that these do not become unduly bureaucratic and act as a barrier rather than a facilitator. Some people – staff students or students with lived experience – may not want help to decide what to do and may simply want to try a one-off session rather than make a more comprehensive learning plan:

> Principle 6: The Recovery College is not a substitute for traditional assessment and treatment.
>
> Principle 7: It is not a substitute for mainstream colleges.

Some of the criticisms levelled at recovery colleges revolve around the misapprehension that in some way the college is a substitute for therapy or mainstream education:

> They are "a cheap alternative to more effective services".
>
> Their courses fail to lead to academic accreditation, recognised by employers (Recovery in the Bin, 2015, p. 1).

Recovery colleges should not provide therapy, nor are they a substitute for formal therapy. It is important to remain vigilant that recovery colleges do not stray into providing therapy, or replacing with less effective alternatives, evidence-based therapies.

However, much of what goes on in mental health services is not formal, evidence based, therapy. Much work is the more general "one to one sessions", "individual work" or "support", traditionally done in isolation that might better be done in a setting where people can learn from each other and benefit from the expertise of both lived and professional experience. Recovery colleges provide such a setting and there is a wealth of research evidence demonstrating both the effectiveness of the peer support (see e.g. Repper *et al.*, 2013) and the supported self-help (Foster *et al.*, 2007; Cook *et al.*, 2011) offered by recovery colleges. Indeed, supporting self-management is defined as a key quality standard for mental health services by the National Institute for Health and Clinical Excellence (2011). The Expert Patient Programmes (Department of Health, 2001, 2006) have demonstrated the effectiveness of providing such support in the form of a course where people can gain support from each other rather than as purely "individual work".

Recovery colleges cannot and should not be a substitute for mainstream education and other learning and training opportunities. Their purpose is to help people to rebuild their lives with a mental health condition not to provide qualifications recognised by employers by replicating, in a

special and segregated, setting, the type of courses available to mainstream education. However, they may equip people to move into mainstream education/training opportunities that could provide the qualifications recognised by employers (if that is the person's choice). Indeed many recovery colleges provide "return to study" or "return to work" courses specifically to assist people in these endeavours.

If recovery colleges are to avoid becoming a de facto alternative to mainstream, educational opportunities, it is important that they examine their curriculum and ensure that it is not replicating, but facilitating access to mainstream learning opportunities. The original UK recovery colleges made efforts to ensure this, but some "slippage" has occurred. For example, if people are to explore the possibilities open to them or do their own research (and indeed claim the welfare benefits to which they are entitled) some very basic computer competence is important essential – so opportunities were set up to enable people to gain basic computer literacy even though there are mainstream opportunities for achieving this. In some recovery colleges the slippage has extended to opportunities to do art, sewing, crafts, caving, wildlife, dancing, gardening, etc. often with "for wellbeing" or "for recovery" added (crafts for recovery, dancing for well-being, etc.). These may all be an important part of someone's recovery, but all are available within communities – the task is to enable people to access them. By providing them within a recovery college, there is a risk of it being the start of the slippery slope back to a traditional, segregated day centre:

> Principle 8: It must reflect recovery principles in all aspects of its culture and operation.

All facets of the operation of a recovery college – language, environment, messages about the possibilities of life with a mental health problem – should reflect the recovery ethos it espouses. Most recovery colleges have created a welcoming, hopeful environment that conveys messages of possibility. While this is important, it may have inadvertently minimised the challenges faced by those living with mental health conditions and thereby alienated some people. One of the criticisms levelled at recovery colleges is that they ignore the very material barriers that people face:

> Take charge of your mental health! Challenge those self-defeating beliefs! You too can recover! […] We have pictures with uplifting words on them like "HOPE" and "EMPOWERMENT" […] Your life doesn't matter. Your experiences do not matter. […] We'll blame your mental distress on you. YOU just have to do BETTER (Recovery in the Bin, 2017, p. 2).

In offering images of possibility, it is important for recovery colleges 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. Perhaps we need to actively acknowledge rather more the huge courage and ingenuity it takes to reclaim/claim a meaningful valued and satisfying life and the need to change the world not just focus on the individual. Perhaps recovery colleges need to think more about a "social model of exclusion" (see, e.g. Repper and Perkins, 2003, 2012, 2015; Kinn, 2016) that recognises the barriers that exist and assists people to understand and assert their rights. Some recovery colleges have started to address such issues[8] but such hey are few and far between.

Fidelity and creativity

How should we respond to recovery colleges drifting from the initial guiding principles?

It would be possible to see such departures as a process of growth and creativity that should be welcomed and allowed to take its course. However, if anything that chooses the label can call itself a "recovery college" then this leads to significant questions about what a recovery college is. The power of traditional mental health service models is strong, and it is likely that some of this movement away from the original principles represents the taming of a radical idea so that it fits in with traditional models and ways of doing things.

At the other end of the spectrum, we could leap to defining "fidelity criteria" and licensing recovery colleges only in so far as they adhere to these criteria. Not only would this stifle creativity and

development, if every facet of a recovery college is defined in a set of "fidelity criteria" it would also stifle the very principle of co-production on which recovery colleges are founded.

Alternatively, we could pursue a course between these two poles. Based on a set of agreed principles we could reflect on the extent to which we are really adhering to these, accept and understand some of the contradictions and dilemmas and work collaboratively to co-produce and co-deliver creative solutions within the overarching framework of the principles.

We may well want to revisit and review the principles from time to time. For example, one challenge that we face is not covered in the original principles (Perkins *et al.*, 2012) but has been added as a critical success factor. As originally conceived, recovery colleges were seen as an integral part of mental health services and a core driver for change within those services: modelling different relationships between mental health workers and people who use services and different ways of doing things in order to drive the recovery-focussed transformation of services (Perkins *et al.*, 2012). In order to achieve this, the recovery college needs to be an integral part of services and an integral part of the offer for people using the service and the staff who work in it. However, one of the critical success factors defined by McGregor *et al.* (2014) is "community facing": working in partnership with community resources and groups to broaden the range of courses on offer; increases opportunities for students to move on to community resources and improve working relationships between NHS organisations and local communities. Some recovery colleges have gone further than this, growing away from the services of which they are a part – sitting as a separate entity on the edge with no real links to other services. This means that their power, both to assist people in their journey of recovery and influence the way in which services as a whole operate, is diminished. Should integration with other services be added to the "key principles"?

Similarly, on the basis of the experience of recovery colleges finding that some students were attending courses repeatedly and over very long periods of time, another item was added by McGregor *et al.* (2014): "progression". This refers to the role of colleges in supporting students to identify and work towards their personal goals for life beyond the college.

Professor Slade and colleagues are currently researching existing colleges to identify common features and key principles. We have to ask how many other "key principles" might we want to add? And, if we go on adding, how many "key principles" is too many to provide a framework for development?

Notes

1. https://cpr.bu.edu/living-well/services/health
2. https://riinternational.com/health/recovery-education-services/
3. www.swlstg-tr.nhs.uk/south-west-london-recovery-college
4. www.nottinghamshirehealthcare.nhs.uk/nottingham-recovery-college
5. www.cnwl.nhs.uk/recovery-college/
6. www.nsft.nhs.uk/Get-involved/Pages/Recovery-College.aspx
7. www.dorsethealthcare.nhs.uk/services/recovery/the-recovery-education-centre.htm
8. See, for example www.cnwl.nhs.uk/wp-content/uploads/Recovery_College_Prospectus_2016-17.pdf

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