RECOVERY COLLEGES

An overview of the international experience

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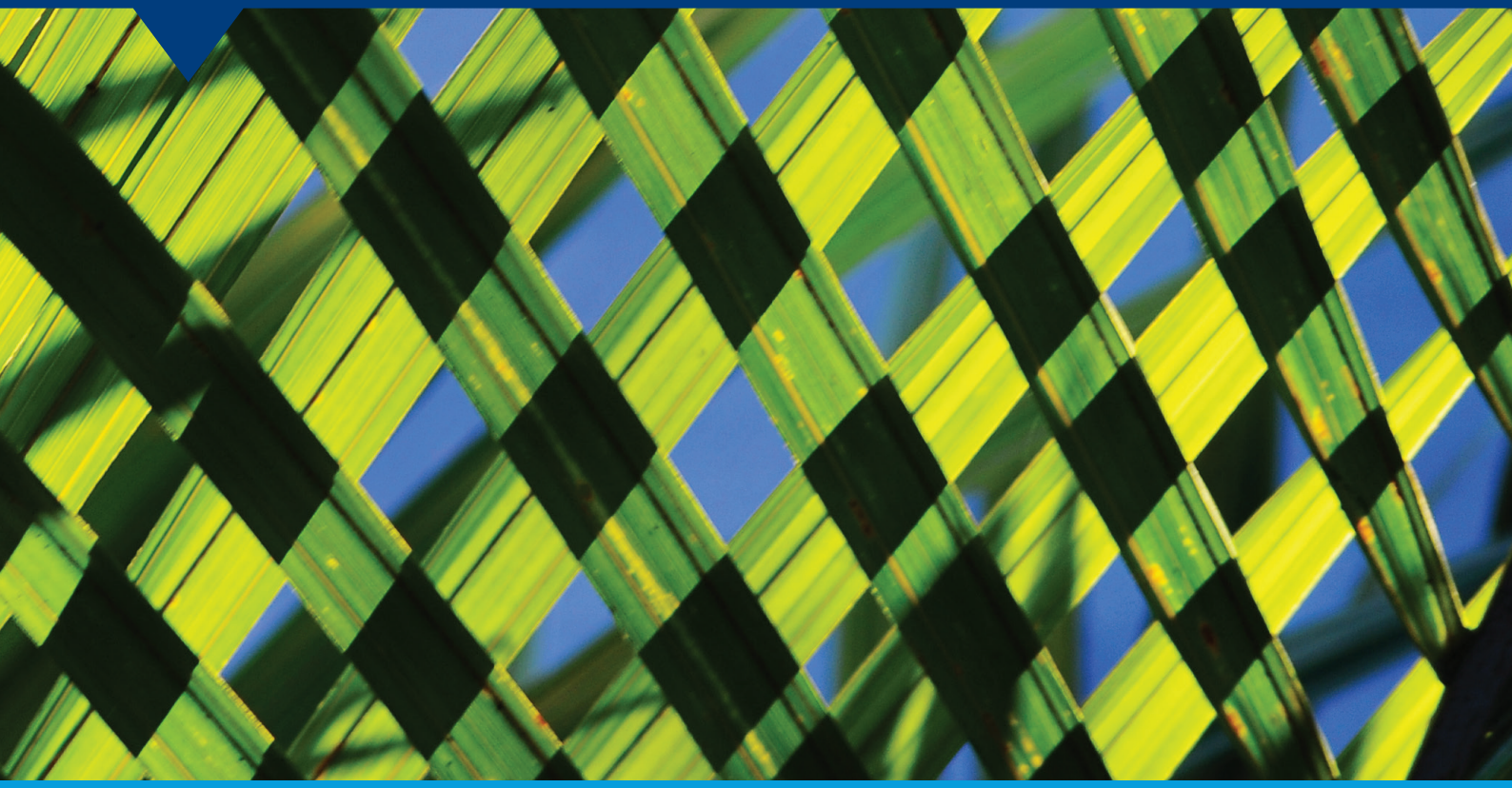

AOD Provider Collaborative

WORKING TOGETHER TO MAXIMISE POSITIVE OUTCOMES

COUNTIES MANUKAU HEALTH

Recovery Colleges – An overview of the international experience

This document provides an overview of recovery colleges overseas, including the aims, key components and potential impacts of recovery colleges established in the UK and Australia. This report was commissioned by the Alcohol and Other Drug (AOD) Provider Collaborative and will be used to inform the development of a Recovery College in Counties Manukau.

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Beginnings

The recovery college concept has its roots firmly located in the international mental health service user/survivor movement of the 1990s, with its focus on recovery as the desired outcome for people with a lived experience of mental distress. Recovery can be defined as living well in the presence or absence of one's mental distress (MHC, 1998) and is underpinned by notions of self-determination, autonomy, and the right to establish a meaningful life as a citizen in the world. Recovery colleges are educational facilities where students learn about recovery, including developing knowledge and skills to support their own or other's recovery. The courses offered at recovery colleges have been developed by people with lived experience of mental distress together with other subject matter experts.

Early versions of the recovery college concept were developed in the United States, in Boston and Vermont, in the late 1990s, followed by META Services establishing a recovery education centre in Arizona, Texas, in 2000 (*Establishment*, 2012). Following these centres, two Recovery Colleges were established in the UK, one in South West London in 2009 and one in Nottingham in 2011 (Perkins, Repper, Rinaldi & Brown, 2012), and by 2015, there were approximately 40 recovery colleges in operation, primarily in England, but also in Scotland, Ireland, Australia, Italy, and Japan (Meddings, McGregor, Roeg & Shepherd, 2015). The available information indicates that recovery colleges are typically situated in the mental health, rather than the addictions, sector.

Aims

Recovery colleges are based on an educational model, which means shifting the emphasis from diagnosis and treatment towards aspirations and learning (Zucchelli & Skinner, 2013). The aims of recovery colleges are to enable people to "discover who they are, learn skills and tools to promote recovery, find out who they can be, and realise the unique contribution they have to offer" (Ashcraft as cited in Perkins et al., 2012, p. 2). The focus is on building strengths and recovery capabilities through educational attainment rather than a focus on health outcomes (*Establishment*, 2012). Recovery capabilities are about people becoming experts in their own self-care and developing skills and confidence to manage their own recovery journeys (Perkins et al., 2012), as well as exploring vocational and personal development (Meddings, Byrne, Barnicoat, Campbell & Locks, 2014a).

To achieve these aims, alongside their focus on recovery, recovery colleges are informed by both adult education theory and rights-based social models of health. Rights-based models of health seek to reduce health inequalities by enabling people to develop their capabilities and increase their access to resources to improve their health. Adult education theory emphasises the importance of learning that builds on participants' strengths and prior knowledge, as well as acknowledging students as active participants in the co-construction of knowledge. In combination, these theories suggest that using an educational approach to support individuals to build on their existing strengths and capabilities will result in an increased ability for individuals to manage their wellbeing, their lives, and exercise control over decisions that affect them.

Key Components of Recovery Colleges

1. **Based on educational principles** – clear structure for lesson plans, courses and terms. Strong educational focus in all documentation and language. Students have "Individual Learning Plans". Tutors or learning and development advisors help students with course selection. Curriculum overseen by a Quality/Academic Board.
2. **Co-production** – everything is co-produced, with co-facilitation and co-learning a frequent occurrence.
3. **Strengths-based** – for students and staff, not problem or deficit-based.
4. **Physical location** – colleges have a physical location in the community. In both the UK and Australia, some are co-located alongside mental health services but most are in the community alongside other agencies, shops, and community venues. Most are designed to be like other colleges, with student cafeterias, computer study spaces and libraries for research.
5. **Person-centred** – the student chooses the courses they are interested in attending; not referral-based. No requirement for diagnosis or risk assessment.
6. **Progressive** – students work towards goals beyond the college and graduation, and are encouraged to take ownership of their own Individual Learning Plan which details their personal educational goals.
7. **Community facing** – active engagement with agencies, organisations, community colleges in the local community to co-produce relevant courses and facilitate pathways into valued roles, relationships and activities.
8. **Inclusive** – recovery colleges are for everyone – people with mental health challenges (whether using specialist services, their GP, or no services), family and/or whānau, mental health service staff, and people from other social sector agencies. Students of all abilities, cultures, ages and experiences are welcomed.

Source: Adapted from Meddings et al., 2015, and McGregor, Repper & Brown, 2014.

Social Connection and Peer Support

As well as learning new recovery skills and knowledge through attendance at recovery college, students benefit from the peer support available with fellow students and peer trainers. This type of social connection "offers images of hope and possibility and allows people to learn from others who have faced similar challenges and use their lived experience to help others" (Perkins et al., 2012, p. 8), and is highly valued by students (Meddings, Guglietti, Lambe & Byrne, 2014b). Alongside this peer support and role modelling, recovery colleges provide opportunities for students to build social networks and connections with other students. These opportunities can help to reduce the social isolation that is often a part of living with mental distress; "like any students, people attending recovery college courses often form relationships that extend beyond the classroom" (Perkins et al. 2012, p.9). Finally, recovery colleges enable people with lived experience, and those without, to learn from each other, and to learn together, thus helping to dismantle barriers of stigma and discrimination.

Co-production is a Key Component

All recovery colleges use co-production to develop the content of their courses, and many use co-production in all aspects of the college. "Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change" (Boyle & Harris, 2009, p. 11). In practice in recovery colleges, co-production means that the expertise of people with lived experience of mental health challenges and the expertise of mental health or other professionals are equally valued and together form the basis of what is taught to students. In many colleges, co-production is also used in all aspects of the college, from curriculum development to developing position descriptions and recruitment processes to developing a framework for outcome evaluation (Meddings et al., 2015). In addition to co-producing the learning content, for most recovery colleges, courses are also co-facilitated, and co-attended by those with, and those without, lived experience of mental distress.

Most colleges in the UK and Australia use a model of co-production with two components to it: lived experience expertise and mental health professional expertise. In the UK, all course are also co-delivered by at least two facilitators – one with lived experience of mental distress and one mental health professional (Meddings et al., 2015). In contrast, according to Mind Recovery College Director Dianne Hardy (personal communication, 21 November 2016), the Mind Recovery College in Melbourne uses a co-production method with three components to it: lived experience expertise, learning and development expertise, and subject matter expertise. Each course is developed and delivered utilising these three components. Sometimes all three aspects are present in one person who develops and delivers the course, sometimes the courses are developed and delivered by multiple people who bring a mixture of the aspects. This model of co-production helps to highlight the importance of learning and development expertise in course development and delivery in recovery colleges.

How Recovery Colleges Differ from Mental Health and Addictions Services and Continuing Education

Recovery colleges are different from continuing education because the courses are all co-produced, often co-delivered and co-learnt, and they are focused on developing recovery capabilities in students, whether those students have their own lived experience, they support people with lived experience, or they just want to know more about recovery. Recovery college courses also tend to be shorter than continuing education courses and have smaller classes.

Recovery colleges differ from mental health or addictions treatment services in that they are firmly based within an education paradigm. In fact, critical to their success is ensuring that training and education expertise are central, so that college courses are high quality education experiences in their own right. Many recovery college staff identify the importance of continually asking themselves, "would a mainstream college do this?" to maintain their fidelity to an educational model.

Typical Courses

In the UK and much of Australia, recovery college courses typically, but not always, cluster around one of the following five categories (Perkins et al., 2012):

1. **Understanding mental health issues and treatments** – for example, *Understanding anxiety; Understanding the Mental Health Act*.
2. **Rebuilding life with mental health challenges** – for example, *Mindfulness; Getting into Study*.
3. **Life skills** – for example, *Managing my Money*; *Problem Solving Skills*; *Making and Keeping Connections*.
4. **Capacity building amongst the peer workforce** – for example, *The Strengths Model in Practice*; *Skills for Educators*.
5. **Family and friends** – for example, *Supporting Recovery and Looking After Yourself as a Carer*.

In the Mind (Australia) Recovery Colleges, these categories are slightly different:

1. **Health and wellbeing** – for example, *My Relationship with my Voices*; *Holistic Self Care*.
2. **Life skills** – for example, *Coping with Christmas*; *Managing Stress*.
3. **Enriching life** – for example, *Food and Mood*; *Mindful Self-Compassion*.
4. **Skills for work** – for example, *Employment Recovery in Action*; *Peer Support Work*, *What's it all About?*
5. **Relationships** – for example, *Understanding Anger*; *Confident Me*.
6. **Family, friends and carers** – for example, *Caring Counts: Living with the Emotional Challenge of Being a Carer*.

Contrasting Treatment Services with the Recovery Education Model

Traditional Therapeutic/Health Model	Recovery Education Model
People are patients/addicts.	People are students. No requirement to disclose diagnosis.
Focuses on problems, deficits and symptoms.	Focuses on strengths, talents, and resources.
Becomes an over-arching paradigm transforming all activities into "therapies".	Supports students to explore possibilities, develop their skills, and achieve their goals and ambitions.
Nature of therapy is chosen and offered by the (expert) therapist after referral and assessment.	Students choose their own courses, become experts in their own self-care.
Maintains the power imbalance and reinforces the notion that expertise lies with professionals.	Staff include peers with lived experience and become coaches who help people find their own solutions.
Referral to social groups.	Students form friendships.
People are discharged or referred on.	People graduate.

Source: Adapted from Meddings et al., 2015

Recovery Colleges' Impact

Because recovery colleges are still a relatively new concept, there is little evidence from formal controlled trials about their impact and outcomes (Meddings et al., 2015). However, preliminary evidence from qualitative and uncontrolled studies indicates that they are effective in achieving a range of outcomes (Meddings et al., 2015; Zabel, Donegan, Lawrence & French, 2016). For example, there is strong evidence that students are highly satisfied, that recovery colleges are popular, and that students feel they have been supported to progress towards their life goals by attending colleges (Meddings et al., 2015; Burhouse et al., 2015).

The Sussex Recovery College has used recovery questionnaires, such as the Process of Recovery Questionnaire, and demonstrated significant improvements on these measures for students attending their Recovery College (Meddings et al., 2015). There is some evidence that after attending recovery college, students go on to mainstream study, gain employment or begin volunteer work (Rinaldi & Wybourn as cited in Meddings et al., 2015) and that students' quality of life and wellbeing improve after attending recovery colleges (Meddings et al., 2015; Newman-Taylor, Stone, Valentine, Hooks & Sault, 2016).

There is some evidence that overall, attendance at recovery college is associated with decreased use of mental health services, both in hospital and in the community. The South West London Recovery College, opened in 2010, has demonstrated a statistically significant reduction in use of mental health services by the College's graduates up to 12 months after completing courses (Burhouse et al., 2015). Although for a small group of students, service use might increase in the first months of attending a recovery college, perhaps because they become more aware of what service options exist (Barton as cited in Meddings et al., 2015).

Finally, there are also indications that attendance at recovery college can have a positive impact on mental health service staff's practice (Zabel et al., 2016).

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Selected Recovery College Websites

South West London, UK
Mind, Australia
Sussex, UK
Nottingham, UK
West Sydney, Australia
Dublin North & North East, Ireland

About the AOD Provider Collaborative

The Counties Manukau AOD Provider Collaborative was formed in 2009 to ensure providers within the Counties Manukau District Health Board catchment area are working together at a systems-level to maximise positive outcomes for AOD (alcohol and other drug) clients. Funded by Counties Manukau Health with additional support from Odyssey, the Collaborative brings together 17 organisations delivering alcohol and drug treatment or related services within the region.

aodcollaborative.org.nz