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# South Essex Recovery College Evaluation

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## Research report

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## Executive Summary

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This report covers an evaluation that took place between March 2014 and March 2015, of the South Essex Recovery College (SERC). The programme follows an adult education model that aims to deliver open, peer led recovery workshops and courses. It was set up with the primary goal to encourage people with mental health conditions to become students, enabling them to better understand their own challenges, and how they can best manage these in order to pursue their aspirations. It facilitates the learning of skills that promote greater self-confidence and recovery. SERC, endeavoured to design and develop a college that embraced the values of recovery colleges elsewhere, notably in encouraging that people become experts in their own self-care, and prioritising lived experience at all stages and levels in its development.

A broad evaluation framework using a mixed-methods process and outcome-oriented approach was adopted. Data was collected in a number of ways: structured self-completion questionnaires, written feedback about the programme from participants, focus groups, and follow up interviews with peer facilitators. Findings are presented against four key areas:

- 1) *The overall management and structure of the pilot program, its organisation and growth.* SERC, after a long and delayed pilot program, offers three courses, over 6 deliveries (3 x Introduction to Recovery; 2 x Taking Back Control; and 1 x Be You). It has met six of its set objectives, and compares poorly to other exemplar recovery college pilots elsewhere in the country. Areas where the recovery college showed poor performance against its set objectives was in the growth and promotion of the college, development of new courses, and volunteer recruitment.
- 2) *The experiences of participating in the programme (process).* Findings across both questionnaires and discussion as part of the focus groups demonstrate that the experience of attending the Recovery College was overwhelmingly positive, for most. Importantly, the courses offered participants tools and new skills and hope for the future, a sense of belonging, a way to meet others and make friendships. This was very

important for overcoming anxieties associated with starting the course. Participants wanted a dedicated space to grow the college further, and enhance the sense of community that the college afforded.

- 3) *Changes over time following participation (outcomes).* The Questionnaire about the Process of Recovery (QPR, O'Neil et al, 2008) was used to measure a change in recovery outcomes before and after course attendance. No significant difference between QPR responses before course attendance (3.22, SD= .56) and after the course (3.45, SD=.57),  $t(17) = -1.694$ ,  $p > .05$  was found. Other bespoke questions were included to explore the student's perceptions of how attending the course affected aspects of their personal recovery. Across all courses, 61% of students reported feeling more hopeful for the future because of attending the course.
- 4) *The impact of peer trainers and co-production on the process and outcomes.* Having peer facilitators, who themselves have experience of mental health problems, was seen as very important. Participants across both focus groups highlighted that the use of peer facilitators was a particularly helpful aspect of the course, offering increased hope for the future and feelings of being able to give back, following the course. Peer facilitators reflected on how the change in identity from student to peer facilitator was challenging, and further support and training was needed. However it was also seen as a personal achievement, rewarding and had increased personal confidence

Six recommendations are provided to guide further development of the college, and act as a benchmark to measure further development and the future success of SERC.

## Contents

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Executive Summary .....	2
Acknowledgements .....	6
List of figures, tables and boxes .....	6
1. Introduction .....	7
2. Context .....	8
2.1. The concept of personal recovery and the move towards recovery focussed services .....	8
2.2. National context, and the defining features of Recovery Colleges .....	10
2.2.1. The evidence base .....	11
2.4 South Essex Recovery College - Aims and Scope.....	12
3. The Evaluation .....	14
3.1. Comments on the chosen evaluative approach .....	14
3.2. Methods and procedure .....	16
3.3 Analysis.....	17
4. Findings .....	18
4.1 Structure, management and growth of the college.....	18
4.1.1. Performance against stated objectives .....	19
4.1.2 Comparing growth to other recovery colleges .....	24
4.1.3. Summary and additional comments .....	25
4.2 Experiences of participating in the programme.....	26
4.2.1 Suggestions for improvement .....	28
4.2.2. Overcoming challenges – barriers and enablers .....	30
4.2.3. Summary .....	31

4.3. Changes over time following participation (outcomes). .....	32
4.4 The importance of peer trainers and co-production .....	37
4.4.1. Providing adequate support and keeping lived experience at the centre of SERC .....	40
5. Recommendations and Conclusion.....	42
5.1. Summary of findings.....	42
5.2. Recommendations .....	43
6. References .....	46
Appendix one – post course questionnaire .....	48
Appendix two – draft focus group schedule.....	52

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We would like to thank the South Essex Recovery College management committee and advisory group, as well all those who participated in discussions and interviews, for their invaluable support and help with this evaluation.

## List of figures, tables and boxes

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Table 1. Differences between a therapeutic and educational approach. (Adapted from Perkins et al, 2012) .....	11
Table 2. Progress against key objectives set by SERC at the beginning of the pilot .....	23
Figure 1. Key principles of South Essex Recovery College (as stated by SERC development committee in December 2013) .....	13
Figure 2. Key functions of process evaluation and relation among them. Taken from Moore et al (2015, p.2).....	15
Figure 3. Exemplar Recovery Colleges elsewhere in the UK .....	25
Figure 4. Differences in participant responses across courses .....	28
Figure 5. Learning new skills.....	34
Figure 6. Differences across courses in feeling hopeful for the future as a result of attending the course .....	35
Figure 7. Number of respondents who agreed that trainers were sensitive to individual needs .....	38
Figure 8. Number of respondents who agreed that it was very important to have a lived experience trainer .....	39

## 1. Introduction

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The South Essex Partnership University NHS Foundation Trust (SEPT) commissioned Anglia Ruskin University to carry out an evaluation of SEPT's implementation of a Recovery College, piloted in Basildon and the surrounding area. This report details the results of that evaluation, which ran from March 2014 to March 2015.

The Recovery College approach follows an adult education model that aims to deliver an open, peer-led education and training curriculum of recovery workshops and courses. The evaluation aimed to investigate the impact that attending The Recovery College has had on student's personal recovery journey and general well-being, and the way in which Recovery College has achieved that. The evaluation also considers how lived experience and co-production influences the process and outcomes of the pilot.

The first part of the report (see section 2) briefly describes the wider context of the introduction of recovery colleges in UK mental health services. In section 2.1 the broader policy context, and the model of personal recovery, within which it operates is described. Section 2.2 the defining features of recovery colleges, and their implementation in the UK and evidence base is discussed. The section conclude with a review of the aims and scope of South Essex Recovery College (section 2.3). Section 3 details the evaluative approach and methodological choices, and describes the methods, procedure and analytical strategy. Section 4 discusses the main findings of the evaluation. These are presented under four sub headings: Structure, management and growth of the college (section 4.1); Experiences of participating in the programme (section 4.2); Changes over time following participation (section 4.3); and the role of peer trainers and co-production (section 4.4). Section 5 concludes the report and presents recommendations for the future.

To note, where direct quotations are presented, the name and any identifiable information have been removed or changed.

## 2. Context

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### 2.1. The concept of personal recovery and the move towards recovery focussed services

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Establishment of Recovery Colleges has been a key tool for mental health services, in their endeavour to move away from traditional services to recovery focussed services. A number of authors have highlighted the distinction between 'clinical' forms of recovery (associated with achieving a pre illness state, reduction in symptomology and preoccupations with cure to a condition) and the model of 'personal' recovery (Repper & Perkins, 2003; Davidson et al 2008; Slade, 2010). In the context of modern mental health UK policy, the term recovery is associated with the latter meaning: one that instils hope for the future and is a way of overcoming losses associated with being mentally ill. It emphasises the process or *journey of recovery* as something that is not static but moving and changing over time, being led by the service user in a re-evaluation of identity (Repper & Perkins, 2003). It has also been referred to as a 'consumer' model of recovery, to reflect its historical roots (see S. 1.6) and to highlight its '*individually defined and experienced nature*' (Slade, 2010, p.2).

By far, the most often quoted definition of recovery is that offered by Anthony in 1993:

*...a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles. It is a way of living in a satisfying, hopeful way and contributing to life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.*

(ibid, p. 527)

This quote emphasises the developmental journey that the model of recovery imparts. Others emphasise the importance of both *living with and living beyond* the adverse impact of a diagnosis, to lead a fulfilling life with hope (Davidson, 2003). Thus, the concept of a journey, of growth, optimism and hope is central to narratives of personal recovery. There is acknowledgement that people have to come to terms with the ordeal that the occurrence of mental health symptoms can have on their lives and incorporate these experiences into a



new sense of personal identity, with belief and hope for the future and regaining a sense of control over one's life (Shepherd, Boardman and Slade, 2008). Leamy et al (2011) undertook a systematic literature review and identified more than 5000 articles. This extensive synthesis found that the recovery process comprised of: Connectedness (relationships, peer support and support groups, being part of the community); Hope and Optimism for the future (belief, motivation to change, hope inspiring relationships, positive thinking and dreams and aspirations); Identity (dimensions, rebuilding, overcoming stigma); Meaning in life (spirituality, social roles and goals) and; Empowerment (control, personal responsibility and strengths), giving the acronym CHIME. Importantly this robust conceptual map highlights the importance of spirituality and social inclusion as important processes for recovery. The themes were similar across heterogeneous studies, including studies that explored perspectives of people of a BME origin, thereby offering a comprehensive framework from which organisational, social and psychological interventions can be targeted.

For mental health services, recovery represents a transformation towards a new way of working, with service users moving towards the centre of the recovery process and where decisions are based *less on professionally defined goals and more on listening to and acting on the service user's wishes* (Slade and Hayward, 2007, p. 81). Therefore, recovery also represents the service user having expertise and knowledge, in addition to the ideas of regaining control over one's lives and future.

One of the key drivers of change towards implementing models of recovery into mental health services was the creation of The Implementing Recovery through Organisational Change programme (ImROC), commissioned by the Department of Health in 2011. In its first phase from February 2011 to December 2012, ImROC worked with 29 NHS funded mental health service providers and their partners to help them refocus mental health services around the principles of recovery. The programme is based on an annual membership scheme and a range of supporting consultancy packages. One of these packages is the ImROC supported Recovery College Network, where organisations at different stages of maturity: both those who have set up a fully established recovery college,

or those who are looking to grow their initial courses and local partnerships who are considering beginning a pilot phase, receive support from the wider network.

## 2.2. National context, and the defining features of Recovery Colleges

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More than 20 recovery colleges form part of the ImROC virtual network (go to [www.imroc.org/imroc-recovery-college-network](http://www.imroc.org/imroc-recovery-college-network).), and many more colleges have been set up independently of the ImROC programme (of which South Essex Recovery College is one – see section 2.3, below).

The overarching aim of the Recovery College is to support people become experts in their own self-care and for families, friends, carers and staff to better understand mental health conditions and support people in their recovery journey. The Recovery College follow an adult education model that aims to deliver an open, peer-led education and training curriculum of recovery workshops and courses. This approach encourages people with mental health conditions to become students and to take control of their well-being and innovating new practices, offering hope, choice, control and opportunity.

This approach is also reflected in the mental health strategy “No Health without Mental Health” (Department of Health, 2011) which defines key outcomes as enabling people to gain:

“ a 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” (ibid: p.1).

Students at the colleges not only learn to manage their condition, they can also learn skills to help them explore their hopes, dreams and ambitions as well as form new relationships. Recovery Colleges also help people to become experts in their own self-care.

Indeed, supporting self-management has now been defined by the National Institute for Health and Clinical Excellence (NICE) as a key quality standard of adult mental health services, as part of the service user experience guidance (NICE, 2011).

A therapeutic approach	An educational approach
<ul style="list-style-type: none"> <li>• Focuses on problems, deficits and dysfunctions;</li> <li>• Theoretically driven;</li> <li>• Maintains the power Imbalances and reinforces the belief that all expertise lies with the professionals in managing their own lives.</li> </ul>	<ul style="list-style-type: none"> <li>• Helps people recognise and make use of their talents and resources;</li> <li>• Assists people in exploring their possibilities and developing their skills;</li> <li>• Supports people to achieve their goals and ambitions;</li> <li>• Staff become coaches who help people find their own solutions;</li> <li>• Students choose their own courses, work out ways of making sense of (and finding meaning in) what has happened and become experts in managing their own lives.</li> </ul>

Table 1. Differences between a therapeutic and educational approach. (Adapted from Perkins et al, 2012)

### 2.2.1. The evidence base

High quality research that has explored the evidence base for the recovery college model is lacking, and results are inconclusive. There is some evidence that peer led self-

management education programmes, such as the recovery college model, may lead to small, short-term improvements in people's self-efficacy, and self-management strategies (Foster et al, 2007). However, this aforementioned Cochrane review found no evidence to suggest improvements to psychological health or quality of life as a result of such programmes (Foster et al, 2007). This review was conducted for all chronic related conditions, and was not specific to mental health.

One of the key aims of recovery models is to offer peer support from both peer trainers and fellow students. Studies looking at the impact of peer support in mental health services is also mixed. In a randomised control trial of a peer support program in London, Simpson et al (2014) found no statistically significant benefits for peer support on the outcomes of loneliness and quality of life compared with patients receiving usual aftercare. However, there was some indication that hope may be further increased in those in receipt of peer support. Conversely, other research provides evidence for the effectiveness and usefulness of peer support within mental health services (Repper and Carter, 2011).

Also, Recovery colleges adopt an educational approach which aims to bring together the expertise of professional and lived experiences, and this fits with a range of 'expert patient programs' that have been found to be useful for long term conditions (Lawn et al, 2007). In addition, evaluations of existing recovery colleges have also been very positive and endorsed in policy (Rinaldi et al, 2012; Repper et al, 2012).

In sum, there is a lack of research in the field, and based on this, the evidence base for recovery colleges is mixed, and in need of further investigation. There is a particular need to pay attention to the context and implementation factors that may help or hinder success to such programmes.

## 2.4 South Essex Recovery College - Aims and Scope

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To conclude this section, the key aims and principles of South Essex Recovery College (SERC), as stated by the SERC development committee are described. Please see figure 1, below. These principles fit well with the established best practice policy guidelines and are in line with ImROC. SERC did not opt to become an ImROC member, which would have

involved additional cost and resources. However, it endeavoured to design and develop a college that embraced the values of recovery colleges elsewhere, notably in encouraging that people become experts in their own self-care, and prioritising lived experience at all stages and levels in its development.

*Key Principles of the South Essex Recovery College*

**Service User Led**

**Including Everyone** –regular public meetings that have attracted numerous people from various backgrounds and introduction of the “Big Recovery Meet”, to look at Recovery in South Essex.

**Quality over quantity** - making sure the development maintains quality and relevance to its student.

**Four Core Courses** - Introduction to Recovery, Telling Your Story, Taking Back Control, Pursuing Your Dreams and Ambitions will be the first cohort of courses developed and delivered in the South Essex Recovery College. The courses will be developed in a co-produced fashion that combines mental health professionals and people with lived experience of mental health conditions. The courses will be a benchmark that all other courses will aspire to meet.

**Hub and Spoke** – The Recovery College will run courses in South Essex on a “hub and spoke” model to deliver courses that meet local needs in community facilities.

**Work in Collaboration** – The Recovery College will work with various organisations to further develop Recovery across South Essex.

Figure 1. Key principles of South Essex Recovery College (as stated by SERC development committee in December 2013)

### 3. The Evaluation

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A broad evaluation framework using a mixed-methods process and outcome-oriented approach was adopted. Data was collected in a number of ways: structured self-completion questionnaires, written feedback about the programme from participants, focus groups, and follow up interviews with co facilitators. Key areas of the evaluation included:

- The overall management and structure of the pilot program, its organisation and growth.
- The experiences of participating in the programme (process) and
- Changes over time following participation (outcomes).
- The impact of peer trainers and co-production on the process and outcomes.

#### 3.1. Comments on the chosen evaluative approach

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While randomised controlled trials (when feasible) are regarded as the gold standard of establishing the effectiveness of interventions, such an approach provides little or no information about how potentially complex interventions may be replicated, or what aspects of the intervention are particularly important to its success (or indeed failure). Such factors become increasingly pertinent as the complexity of interventions, and their proposed number of moderators, increase. Following on from this, process evaluation has been recognised as extremely important to effective and meaningful evaluation, as highlighted by bodies such as the Medical Research Council. Nevertheless little guidance has been published on how best to carry these out.

This evaluation acknowledges the framework set out by Moore et al (2015) (see figure 2, below). Notably this framework emphasises the importance of fully reporting the contextual factors that shape theories of how the intervention works. In addition, the implementation process, and participant responses to the interactions are seen as important sources of information. Thus qualitative approaches are a sensible and informative assessment to adopt. This was particularly so, given the small scale nature of this pilot phase, and the

additional aims of the evaluation concerning the experiences of participation, and the value of co production on the pilot phase.

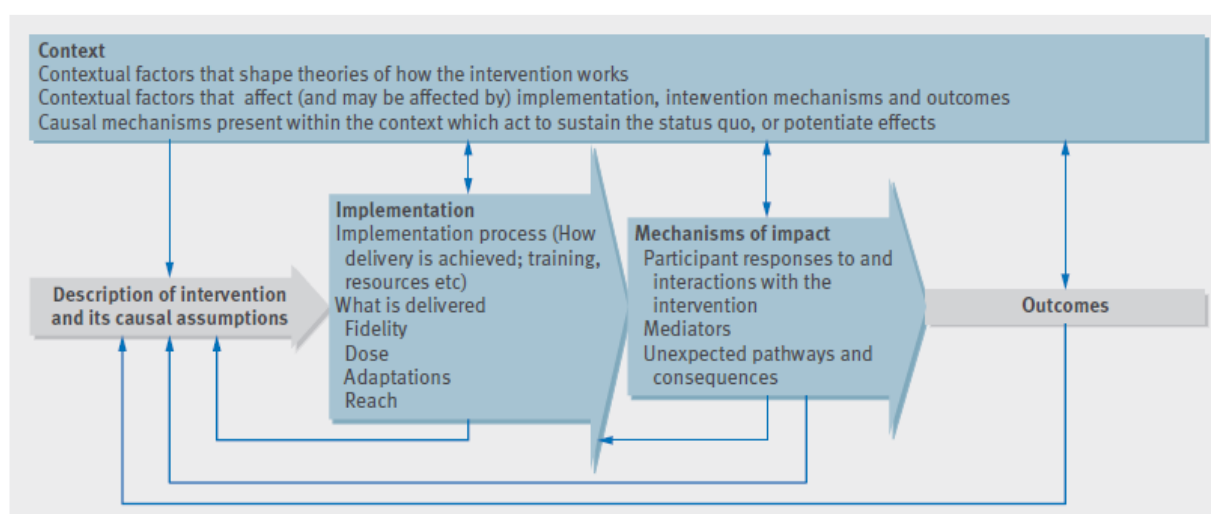


Figure 2. Key functions of process evaluation and relation among them. Taken from Moore et al (2015, p.2)

Finally, consideration was given to the choice of outcome measures used for this evaluation. Good and innovative practice should, in theory, produce positive outcomes. However, there has been much discussion in the health services literature about how best to measure these. In considering measurement of outcomes for recovery, I have followed the timely and comprehensive best practice guidelines published by ImROC in 2014 (Shepherd et al, 2014) and published elsewhere by Boardman, Slade and Shepherd (2013). This briefing paper explored the key outcome domains of measurement available in the field, and their evidence base. Recommended recovery outcome domains from this report included: Quality of recovery supporting care, Achievement of individual recovery goals, Subjective measures of personal recovery and, Achievement of socially valued goals. Interestingly the domains 'Quality of life and wellbeing' and 'service use' were deemed as more problematic in this context<sup>1</sup>. These problems would have become increasingly apparent when taken in the context of a small-scale evaluation of a pilot program, where generalisations to service use were not applicable and interpretations meaningless. Thus, I decided that a subjective measure of recovery would be the most appropriate measure to include for this purpose.

<sup>1</sup> Although, to note, service use is included in the NHS Outcomes Framework as a relevant item. (Department of Health, 2013)

## 3.2. Methods and procedure

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To measure individual recovery outcomes associated with the courses, the Questionnaire about the Process of Recovery (QPR) was selected (Neil et al, 2008). This questionnaire demonstrates good reliability and validity (Law et al, 2014) and was highlighted as the only measure that encapsulates all five areas of recovery in a recent systematic review (Shranks et al, 2013). It consists of 15 items, worded as statements and scored on a 5 point likert scale ranging from '*strongly disagree*' through to '*strongly agree*'. The questionnaire was administered to students during the first week of attendance of the course (pre course phase) and immediately following the course (post course). Responses at the pre and post phase were paired within subjects, as part of the analysis process.

Additional bespoke items were added to the questionnaire that was administered at the end of the course. These included items used in other exemplar evaluations of Recovery Colleges in other parts of the UK (see Rinaldi et al, 2012). For example questions such as '*I feel more hopeful for the future as a result of attending the course*' [strongly disagree; disagree; neither agree or disagree; agree; strongly agree] were used to explore the students direct reflection on how course attendance linked to reflections on personal recovery (hope is one of the five constructs associated with the personal model of recovery – see section 2, for further description). Other items explored how the course has led to learning new skills, as well as exploring the importance of the facilitator having lived experience of mental health conditions. Additional open ended questions were also included, to allow for qualitative comments to be incorporated. The full questionnaire (post course) is shown in appendix one. In total, 41 students returned questionnaires, however of these only 18 had paired responses (both pre and post course questionnaires completed). 28 responses were received following the course delivery.

As alluded to above (see section 3.1), a qualitative approach was an important aspect of this evaluation. Two focus groups were conducted between 2 and 4 weeks after completion of the course. I recruited students for the focus group by placing a sign up sheet on the last day of both the Be You and Taking Back Control courses. I subsequently contacted



interested potential participants and discussed the format of the session in more depth, ensuring all relevant participant information was understood. Written consent was collected at the start of the focus group session. The focus groups each comprised of six students who had participated in the course. The aim of these focus groups was to explore the groups experience of attending the course, the personal impact of attending the course, the strengths and areas for development of the recovery college, as well as a consideration of the how important co production and the inclusion of peer facilitators was to students. Each focus group lasted for one and a half hours. The topic guide used can be found in appendix two.

An additional group interview with two participants was conducted with peer facilitators towards the end of the pilot. The peer facilitators were enrolled as students at the beginning of program and subsequently volunteered to facilitate the 'Introduction to Recovery' and 'Taking Back Control' courses that were delivered later in the pilot, (from January to March 2015). The interview lasted one hour.

### 3.3 Analysis

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The focus groups and interviews were recorded and later transcribed. A thematic analysis was employed (Braun & Clarke, 2006). According to Braun & Clarke (2006) *a 'theme captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set'* (ibid: p. 82). In this context the themes were built in consideration of the key aims of the evaluation. That is: the overall management and structure of the pilot program, the experiences of participating in the programme (process), Changes over time following participation (outcomes) and, the impact of peer trainers and co-production on the process and outcomes. Thematic analysis is, however, a broad term and may result in many interpretations and approaches to the analysis process.

The statistical package, SPSS, was used to record the questionnaire responses. A repeated measures t test was performed to explore the difference between pre and post

responses on the QPR questionnaire. However, given the small sample size, generalizability and inference is not a priority in the reporting of results.

Overall, findings from the evaluation are not directly generalisable, as they are based on small participant numbers and are context-dependent. However, they serve as a useful tool for identifying best-practice approaches applicable in similar contexts, particularly where they are considered alongside other comparable studies.

## 4. Findings

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This section describes the main findings of the evaluation. This section is structured in relation to the evaluation components and aims set out in section 3. That is, an evaluation of SERC in relation to:

- The overall management and structure of the pilot program, its organisation and growth.
- The experiences of participating in the programme (process) and
- Changes over time following participation (outcomes).
- The impact of peer trainers and co-production on the process and outcomes.

All direct quotes use pseudonyms to protect the identity of the participant involved.

### 4.1 Structure, management and growth of the college

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In table 2, performance against stated objectives if he SERC are described. I then discuss how the college has progressed, when comparing it to other Recovery Colleges in other parts of the UK, at a similar point in development (e.g. growth of college during the pilot phase of development and implementation). The final sub section highlights some of the challenges the SERC has faced in its structure, management and growth.

#### 4.1.1. Performance against stated objectives

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In order to consider how SERC has progressed, it is fruitful to explore how it has performed against its own stated objectives. The objectives described in table 2, below, were created by members of the SERC steering group during the early planning phases of the recovery college pilot, early in 2013. These were shared with me at the start of the evaluation early in the spring of 2014, by Andrew Gordon, the Development Lead for SERC during that period.

I include an additional column detailing whether the college has met these stated aims. This is based on information available to me at the time of writing this report (May, 2015). Many items require verification from documentary sources. The document therefore serves as an approximate representation how the SERC has progressed against its set objectives, to guide further planning.

What will we measure	How will we measure it	The ideal outcome	Has the objective been met?
<b>Structure</b>			
Recruitment of key staff (development and assistant development leads) and do they have lived experience of mental health conditions	The number of staff employed will be gathered as will the number of staff with lived experience of mental health conditions	2/3 Key staff have lived experience of mental health conditions during the development.	<b>Partially fulfilled.</b> Achieved but not sustained. The development lead resigned half way through the pilot due to ill-health. One Admin support staff was recruited to bank to support the development lead with administration. Other key staff are mental health professionals (lived experience unknown).
The establishment of a Recovery College steering committee (RCSC)	Are the minutes of the RCSC being fed into Anglia Ruskin Health & Well Being steering group?	The Recovery College steering group established and operational.	<b>Met.</b> The steering group was established and became the management committee for the pilot project. Minutes were kept, but not sent to ARU. A half way report was produced.
Volunteer Recruitment.	The number of volunteers working on the South Essex Recovery College.	The Recovery College will recruit at least five volunteers to the project.	<b>Not met.</b> Four volunteers were recruited to the project

Peer Trainers Recruited.	The number of peer trainers recruited.	The Recovery College will recruit at least two peer trainers to the project.	Met.
<b>Process</b>			
Student database	The Recovery College will measure the number of people who have contacted us interested in attending a course.	The Recovery College will have at least 50 people contacting us who are interested in attending a course.	Met* *Record of 150 contacts expressing an interest in the Recovery College and attending the courses to whom information packs were sent. Some student data lost following staff changes.
The enrolment of students in courses.	The Recovery College will measure the number of students that have enrolled in its courses.	The Recovery College have at least 24 students enrolled by May 2014. The minimum amount of a students required to run a course is 6.	NOT MET Delayed implmentation. First course delivered in June 2014. 3 courses and 6 implementations delivered between June 2014 and March 2015. One delivery cancelled due to low student numbers,
Student attendance.	Sign in sheets for each course session.	The Recovery College will look to have an average of at least 60% in attendance rate.	Met For courses that ran, an approximate attendance rate of between 65 and 75% has been estimated.

Online Presence.	The number of “likes” on its Facebook page.	The Recovery College will look to have at least fifty likes on its Facebook page.	<b>Partially met</b> An active face book page was present in 2014, and received 150 likes. Not active at end of pilot.
	The amount of “hits” the website has generated.	The Recovery College will look to have at least 100 hits on its website.	<b>NOT MET</b> A website was not developed
Courses Delivered	The Recovery College will measure how many courses it has delivered.	The Recovery College will deliver four courses.	<b>NOT MET</b> 3 courses delivered
<b>Outcomes</b>			
Students General Mental Well Being	Students optimism and hope will be measured before attending a course, and upon graduation	The Recovery College will gather baseline data for student’s mental wellbeing and note an improvement in student’s mental wellbeing.	<b>MET</b> Information collected as part of the evaluation
Student goal fulfilment	The Recovery College will work with students to set ‘goals’ before attendance of a course. The Recovery College will measure if the goals have been	The Recovery College hopes to establish a personalised goal with a student upon enrolment. The Recovery College will ask the student if they felt more confident of achieving their goal as a result of attending the Recovery College and note an improvement. The	<b>Met*</b> All students included their goals for attending any course as part of their application and this was informally evaluated in the last session of the courses. As part of the formal evaluation,

	achieved during their time with the College.	Recovery College will also measure if a student has achieved their goal in their time with the College.	progress against goals also recorded(see S. 4.2)
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**Table 2. Progress against key objectives set by SERC at the beginning of the pilot**

From the table it can be seen that only 6 out of the 12 stated objectives were met in full. These are: *The Recovery College will recruit at least two peer trainers to the project; The Recovery College steering group established and operational; The Recovery College will have at least 50 people contacting us who are interested in attending a course and; The Recovery College will look to have an average of at least 60% in attendance rate; The Recovery College will gather baseline data for student's mental wellbeing and note an improvement in student's mental wellbeing<sup>2</sup> and, finally; progress against goals will be measured.*

The areas where the recovery college showed poorer performance against its set objectives was in the growth and promotion of the college, development of new courses, and volunteer recruitment.

#### 4.1.2 Comparing growth to other recovery colleges

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Growth of SERC during the pilot was poor, when compared to other recovery colleges in the UK. Figure 3, below, provides information about the growth in the early phases of two recovery colleges, elsewhere in the UK. Both are exemplars of recovery colleges in the UK, having received acclaim for their work. In the first year, both Nottingham and South West London offered 12 and 8 courses, and this has subsequently grown to over 100, and 50, respectively. In comparison, SERC, after a long and delayed pilot program, offers only 3 courses, over 6 deliveries (3 x Introduction to Recovery; 2 x Taking Back Control; and 1 x Be You) and across different locations (Southend, Basildon, Rayleigh, Grays).

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<sup>2</sup> This data was collected as part of this evaluation



<p><b>The South West London Recovery College</b> opened with a core staff complement of one full-time mental health practitioner and four part-time peer trainers providing eight pilot courses with some sessional input from staff in other teams within the organisation. By 2010 it offered 52 courses in 11 locations serving around 50 people per day. A total of 1350 different people used the College in its first year of operation.</p>	<p><b>The Nottingham Recovery College</b> started with a core staff complement of one full-time mental health practitioner and 12 courses run by four sessional peer and sessional staff trainers drawn from other teams within Nottinghamshire Healthcare NHS Trust. In its third term the College offered 101 courses spanning 45 different topics, running in eight locations.</p>
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Figure 3. Exemplar Recovery Colleges elsewhere in the UK

#### 4.1.3. Summary and additional comments

In summary, SERC has failed to meet in full many of its set objectives and shows very poor performance when compared to successful colleges in other regions of the UK. This potentially suggests that SERC lacked vision and experienced significant challenges in implementing a sustainable growth strategy. There are many factors that may have been particularly important in explaining the poor performance. For example, SERC did not opt to join the wider ImRoc program (see section 2) where valuable expertise and support could have helped guide the development and growth of the college further. In addition, the management of the college underwent significant and disruptive change during its pilot phase. Having said this, in looking at both the student experience of the program (S. 4.2)

and recovery outcomes for students (S. 4.3), a more optimistic picture emerges, suggesting that opportunities for future development exist.

## 4.2 Experiences of participating in the programme

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Overall, student experience across all course deliveries was very positive, with the majority of students stating that course content exceeded students' expectations (see figure 4, below). In addition, 82% of respondents (23 out of 28) agreed that the course content was delivered at the right pace.

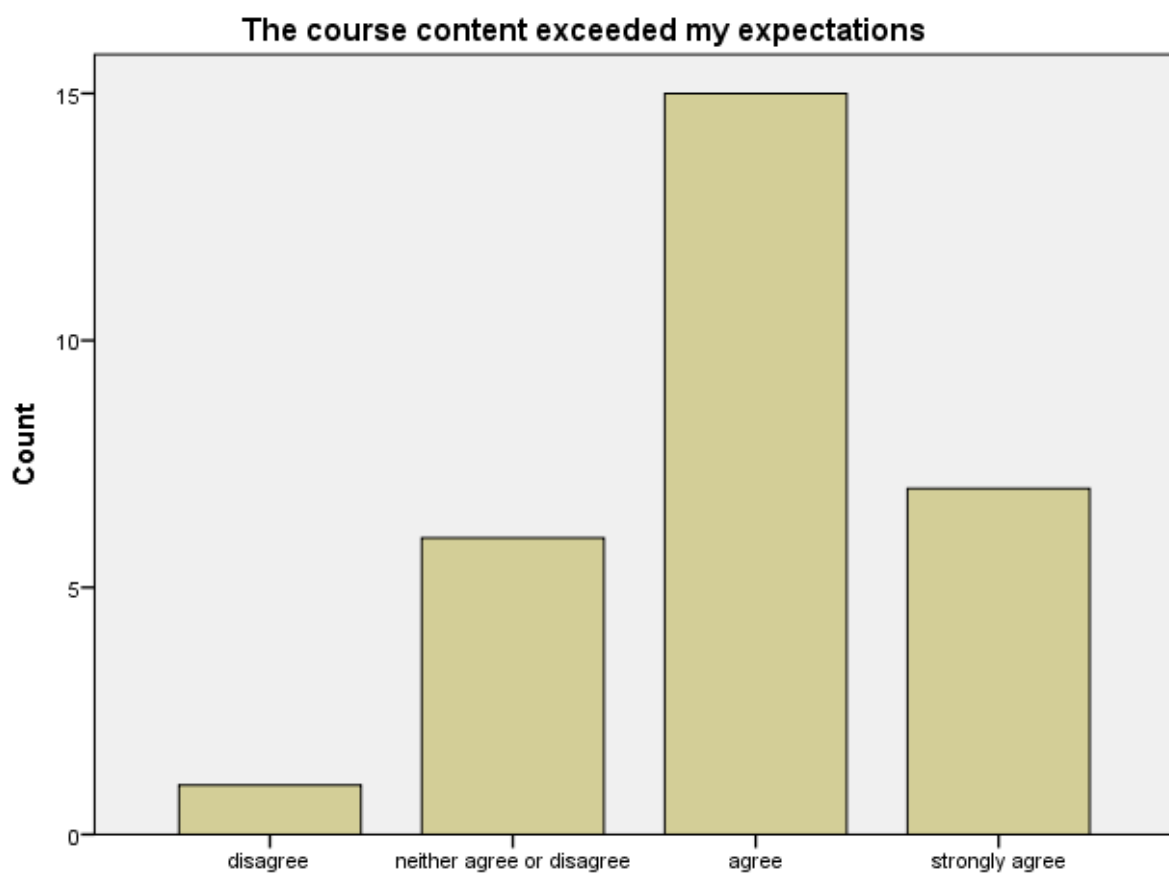


Figure 4. The course content exceeded expectations

*Han: I've never been to a group like it before. I think it was absolutely brilliant. I like I say, I think we all feel, and I think I can speak for all of us all that we really do miss it. It played a really big part in our lives and it had quite an impact on our lives. We didn't realise it at the time. When we sort*

*of step back from it, ... you look over it and think what you realise what you did get from it and I've never been on any other courses when I felt like this. ....to one of the 'recovered'[peer facilitator], I forget what her name was, but I said to her, whatever course comes our way, I said, I'd be glad to go to every single one of them*

Han's quote above illustrates more than just a statement of agreement that the course met expectations, but displays an overwhelmingly positive appreciation of having attended the course<sup>3</sup> and a sense of loss that it ended.

This positive feedback appears across courses, as can be seen in figure 4, below. For the Be You course, all but one respondent agreed (4) or strongly agreed (5) with the statement that 'the course had exceeded their expectations'. Introduction to Recovery and Taking Back Control fared slightly worse on this question, but nevertheless, the majority of respondents agreed with the statement.

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<sup>3</sup> To note Han attended the Be You course in June 2014.

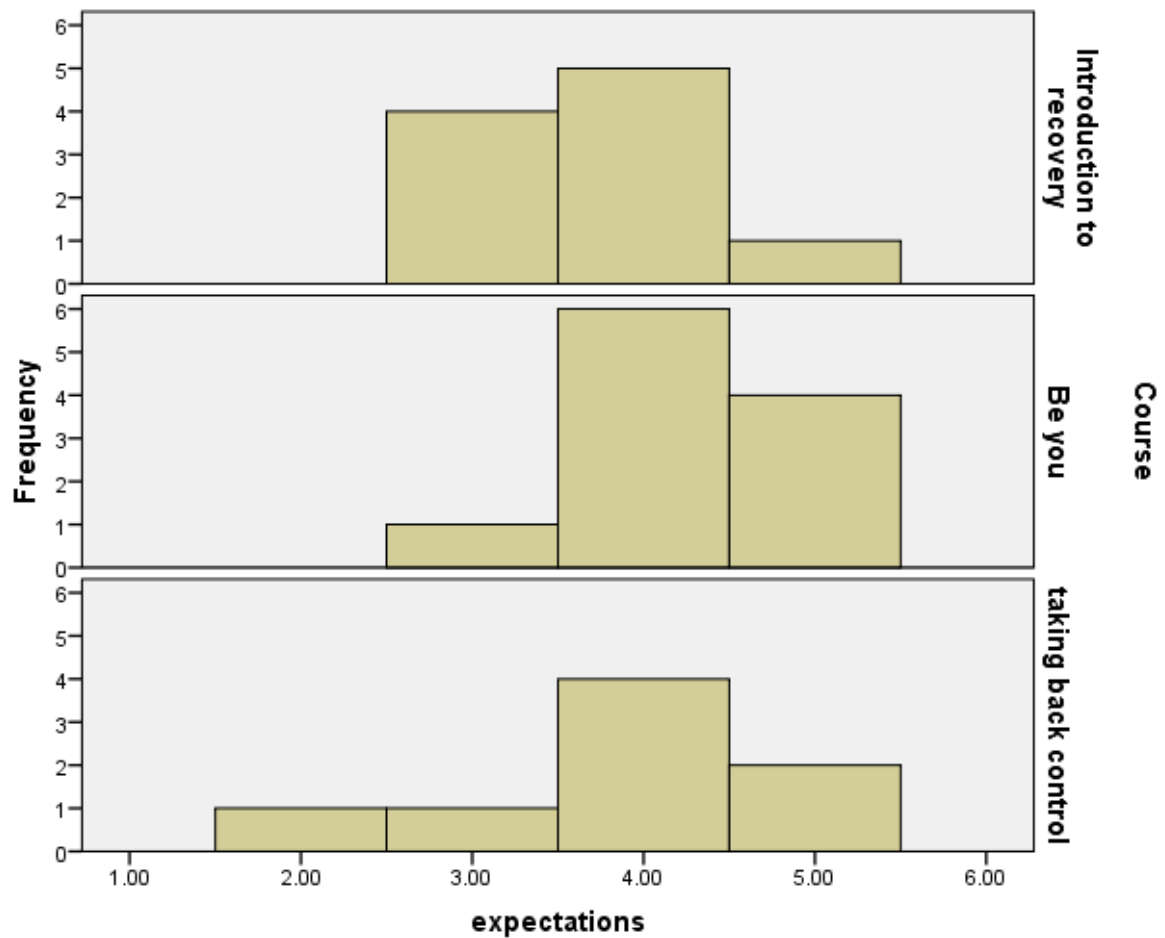


Figure 4. Differences in participant responses across courses

#### 4.2.1 Suggestions for improvement

Participants from across both focus groups felt that the course needed to be longer with more consideration given to the venue, location and timings. In addition, participants referred to more consideration needed to endings, looking to the future beyond the course.

*Obi: Yes, I want to echo that, because although we sort of found out it was 6 weeks by the end, because it probably took us 2 weeks to get going, and if it take 2 weeks to get going, you've got 4 left, and if it was, as she says, 10 or 12 weeks, um then you've got. I mean it gives you that 2 weeks buffer to get into it and you've then still got 8 or 10 weeks to really crack on.*

.....

**Han:** *I find though, I mean it's a brilliant course, that what worries me with us is that when everything does stop what is there going to be for us?*

.....

**Amy:** *I think some people struggled, because I know some people had to get a bus and public transport and I think locations need near a bus stop or train station, because people without cars need to get there too.*

The quotes above also point toward the importance that focus group participants placed on having continuity beyond a 'one off' course, and instead the need to consider a larger program of courses, where people can engage with the Recovery College as a longer term contact, as somewhere to belong, develop and move forward in their individual recovery journeys. This was combined with a sense that students felt a genuine commitment to the college, unlike other group settings, and students felt an increased sense of responsibility to make the most of opportunity that the recovery college offered. See the first excerpt, below. A strong sub theme that linked to this was the recommendation made by both focus groups, to offer a fixed venue, a dedicated space, where students could go and feel that sense of belongingness, and subsequently take increased ownership and be involved in the future development of SERC (see excerpt 2, below).

**Andrew:** *I used to go to the coping skills of mental illness [a group organised by mind]. The first week there was four five people by the third week there was only me there. So they cancelled the course.*

**Martin:** *And it's heart braking*

**Tabatha:** *Where as this, it's a college... we made a commitment, we're going, and its making our mind work, whether we want it or not, there's good or bad days, but we turn up.*

.....

**Peter:** *But I'd also like to see the recovery college go on and have follow up groups and have peer groups that come out of those. I mean I discussed the group with the facilitators and we spoke about other recovery colleges, like the one in South London, and how they have their own centre, somewhere where you can meet people and something like that where people can go and form their own little groups, we discussed*

*that and groups of people going off and doing things together. I can see the recovery college becoming quite useful in that direction, but again my feelings are you then get into the budgetary arguments about health verses social care. What side of the line do you fall?*

.....

**Emma:** *Can I ask? I am just continuing this a little bit, but, about the 'how it is ending', how it ended, the course, how was that? Was there a need to think about what is beyond and how did that happen?*

**Tabatha:** *Yes,*

**Tracy:** *Yes, because there is nowhere they had no signposting about what to move onto from this,*

**Peter:** *But again, they don't have a venue of their own, so it wasn't like if you pop back next week for a coffee*

**Tabatha:** *It's just like any other event, we've been thrown out to the wolves, thank you very much.*

**Peter:** *That's exactly how the mental health system feels – you get help up to a certain point, then you're on your own.*

#### 4.2.2. Overcoming challenges – barriers and enablers

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Finally, in this section, I present challenges that some people found to be particularly personal to them, and ways in which their experience of the college helped or hindered this.

A few respondents, when asked if there was any particular anxieties that that they had about attending the college, reported feeling anxious about joining the group, of fitting in, and of not wanting to feel out of place, or incapable to doing things. This anxiety at the beginning of the course manifested itself in different ways for different people. See excerpts below, as examples. Interestingly there was some disagreement between participants about

using the label 'College'. For some this was helpful and important<sup>4</sup> to them, creating a sense of prestige, as well as overcoming stigma when talking to people in the wider community. The label 'College' was also seen to emphasise a formal learning space. However, for other people the term 'College' created anxiety and worry (see Tabatha, below).

***Martin:** Confidence. About not being liked, you're going into a big group and you don't know anyone there. And that was quite a worry, but after you got to know everyone that was you know reassuring ok.*

***Tabatha:** The word 'college' was frightening. Because of writing words, and I'm dyslexic and if I have to do lots of spelling and things like that and I find that off putting.*

***Martin:** I found it better though calling it College. You know because I was telling people 'Oh I'm off to college'*

*[joint laughter in room]*

*Better than saying to people [cross talk – can't hear word] so I found it a bit better for me and so now I've got another course to do and I say, 'I'm off to college!'.*

***Peter:** I mean the name college is a bit kind off putting. But for me, I also like the label college because it makes it clear it's a more formal thing, because I mean the other groups are a bit informal and just sitting in a circle throwing ideas around instead of a presentation or whatever. To me it differentiates it from other therapy things I've done. I think the tag college suited the content better.*

In sum, anxieties and worries about attending the course were present amongst focus group participants, and these were manifested in different ways. A strong theme that emerged across focus groups and all participants was the hugely helpful role of forming friendship with peers, feeling able to express oneself in a supportive and trusting environment, and the huge importance of having facilitators with lived experience of mental ill health (see section 4.4, for further discussion)

#### 4.2.3. Summary

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<sup>4</sup> To note, this emerged from discussion amongst the group, as oppose to following a direct question.

In summary, findings across both questionnaires and discussion as part of the focus groups demonstrate that the experience of attending the Recovery College was overwhelmingly positive, for most. Importantly, the courses offered participants tools and new skills for the future, a sense of belonging, a way to meet others and make friendships. This was very important for overcoming anxieties associated with starting the course.

Participants wanted a dedicated space to grow the college further, and enhance the sense of community that the college afforded.

### 4.3. Changes over time following participation (outcomes).

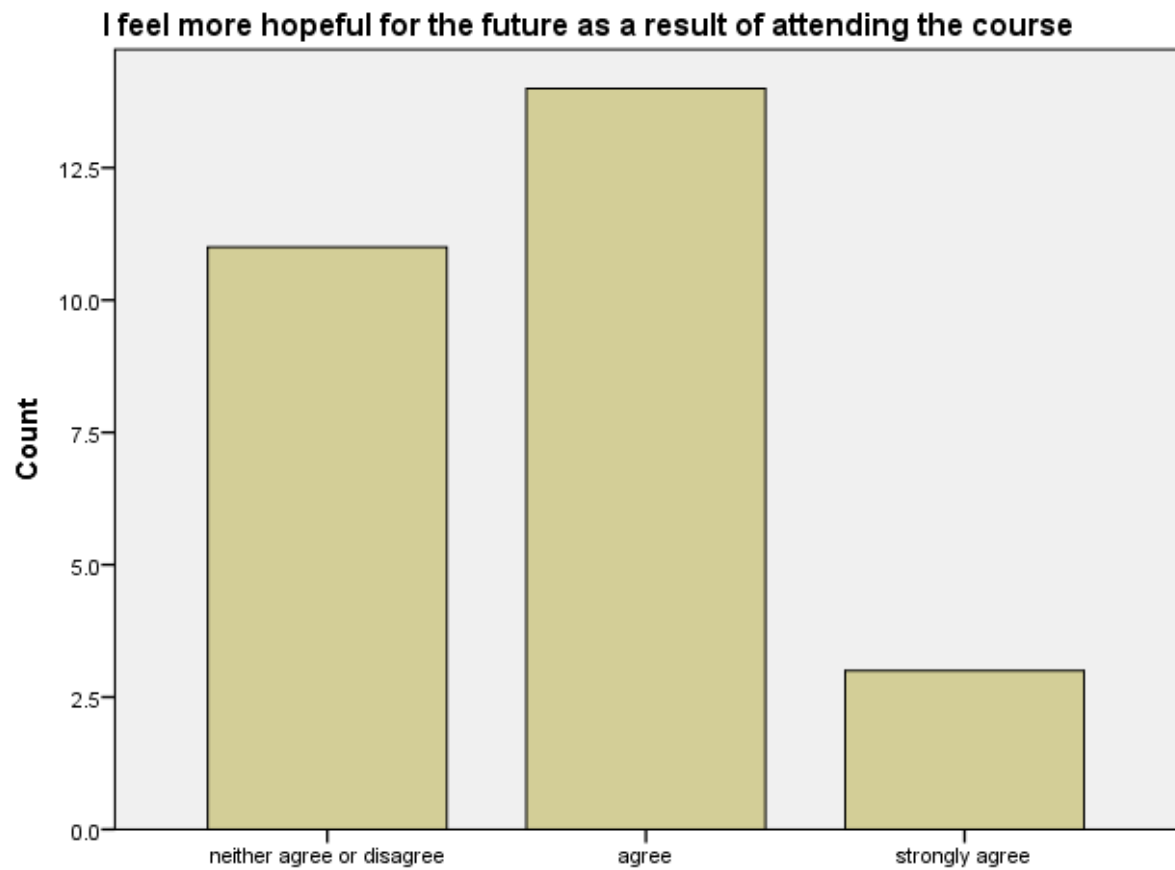
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As discussed in Section 3, the outcome measure selected for this evaluation was the Questionnaire about the Process of Recovery (QPR) (Neil et al, 2008). In order to investigate whether attending a course at the SERC was associated with a change in the reported responses given on the QPR questionnaire, a repeated measures t test was performed. Analysis found no significant difference between QPR responses before course attendance (3.22, SD= .56) and after the course (3.45, SD=.57),  $t(17) = -1.694$ ,  $p > .05$ . This means that there was no observed difference in student's self-reported recovery following attendance at SERC.

Due to insufficient sample size, no investigation was carried out on whether there was a significant change in score on the QPR depending on course attended.

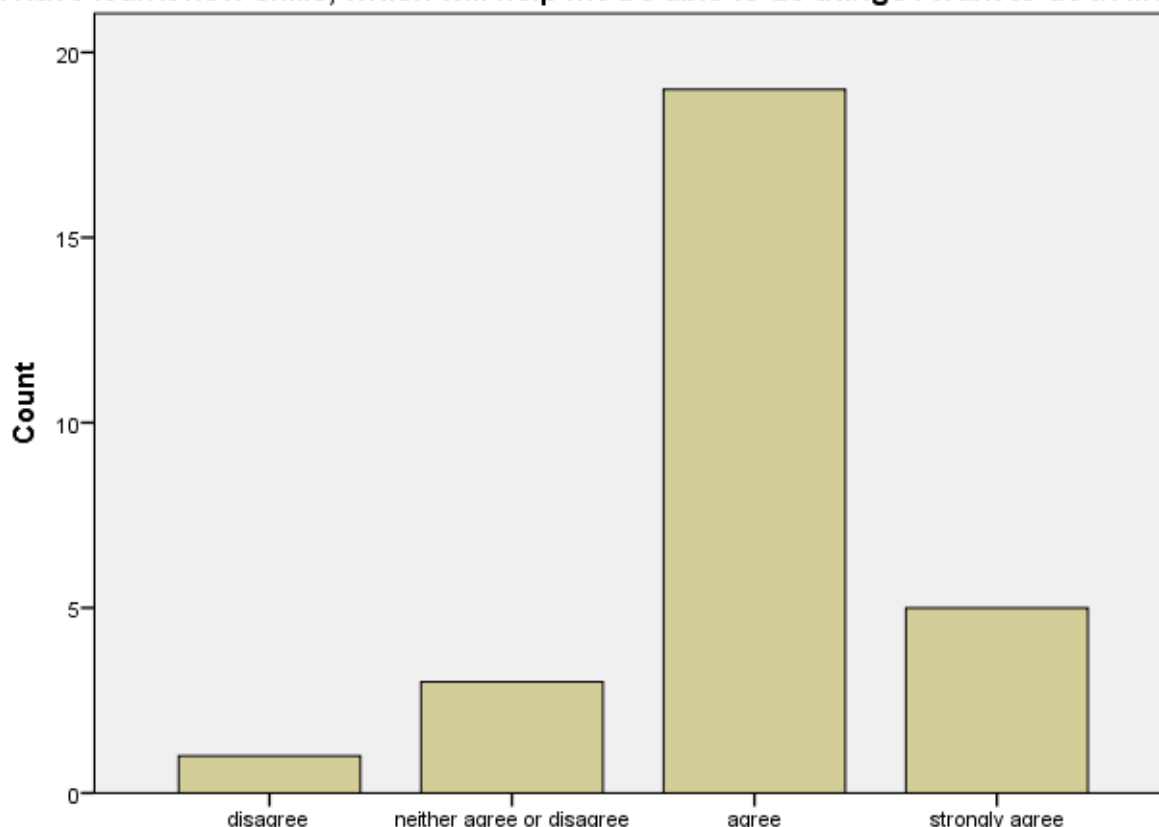
Other bespoke questions were included to explore the student's perceptions of how attending the course impacted on aspects of their personal recovery. As can be seen from the figure 4, across all courses, 61% (17 out of 28 students) reported feeling more hopeful for the future as a result of attending the course. In addition, 85% of respondents (24 out of 28) either agreed or strongly agreed to the statement 'I have learnt new skills that will help me be able to do things I want to do in life' (see figure 5).





**Figure 9. Hope for the future because of attending the course**

**I have learnt new skills, which will help me be able to do things I want to do in life**



**Figure 5. Learning new skills**

Some difference in response is observed across courses (see figure 6, below). For the Be You course (the first course delivered at SERC, in June 2014), over 90% of respondents reported feeling more hopeful for the future as a result of attending, and this compares to less than 30% of the Introduction to Recovery students' reports. A likely explanation for the difference observed is due to the length of courses. The Introduction to Recovery course was a short course (2 weeks) in length, serving as an introductory course for participation in the college. However, some difference is also observed between the two remaining longer courses also (Be You vs Taking Back Control (delivered in February/March, 2015)). This may be related to the implementation issues and change in management part way through the pilot. These are discussed in Section 4.1, above. However, it should be noted that extreme caution is necessary in interpreting these findings. As mentioned previously, insufficient sample size means that appropriate statistical analyses cannot be undertaken to explore any between group effects.

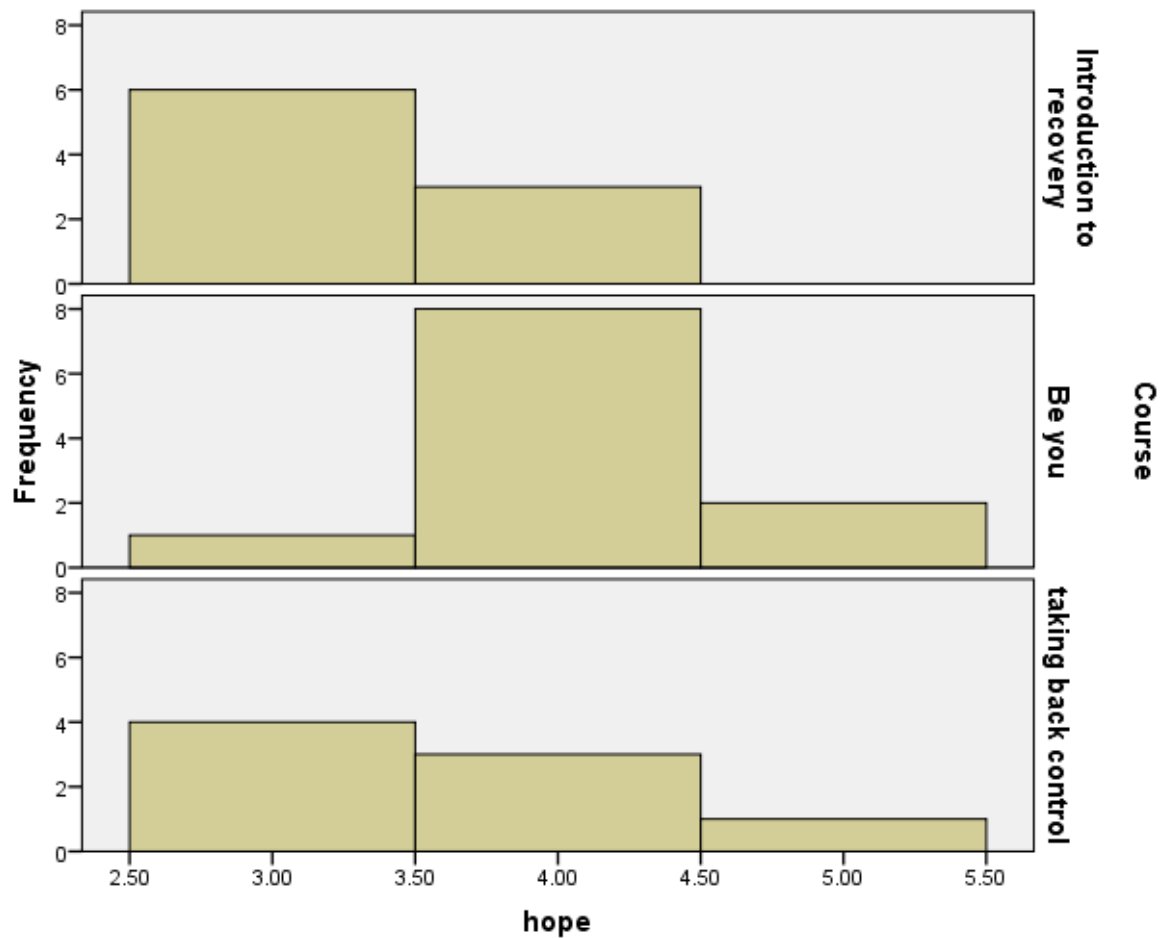


Figure 6. Differences across courses in feeling hopeful for the future as a result of attending the course

In summary, there is no significant difference in the measure of recovery before and after course completion. However, the majority of students reported feeling more hopeful for the future as a result of attending the SERC. This is supported by qualitative comments, both from the questionnaire data, and the focus groups. For example, a respondent to the questionnaire following the Taking Back Control' course writes:

*'Sorry, I'm Bi Polar and I change like the weather. You have good days, and bad days, but just like the weather, it doesn't last.... so now instead of thinking 'bad days' I've learnt to dance in the rain'*

Questionnaire comment following 'Taking Back Control' course.

Similar comments also emerged as part of the focus groups, with the majority of participants reflecting that attending the course had positively impacted on their own recovery.

**Luke:** *And like I say, I was going through a right bad time and um, I mean the doctor, the psychiatrist, and the medication can only help you so much, and I got a lot more out of that group than like medication and the psychiatry side of it you know.*

**Lotus:** *Whereas going to the course, I began to feel more positive as a person and I think that is very important.*

**Kathleen:** *I suppose again, I mean, for myself personally, I went there specifically to well build up confidence, to keep building and building, that's what I really needed myself because my confidence has been shot over the years basically and that is where I wanted, that's where I was at and this course has done something for me, it's helping me to be myself, as 'be you,' you know, abbreviated for 'being yourself', and its slowly building up and has built quite a bit of my confidence already.*

Interestingly, Luke's comment points towards a limited offering of other forms of psychological or social support available as part of 'normal services', emphasising that psychiatric medication is a dominant part of service users' interactions with mental health services. Indeed, this emerged across both meetings, when discussing how the course compares to other services they have received from within SEPT.

**Martin:** *And it's like as well, when you've got a mental health problem, you go and see the psychiatrist, they give you medication, and that's it. You're left to your own devices. So you need something like this to help you understand what you've got and how to deal with it. And the coping strategies, but you know with, you know it's vile really,*  
**Emma:** *And would you say that is, from your perspective and your experiences, that that is all there is? You know, you go to your psychiatrist and get medication?*

[cross talk][many attendees responding in the affirmative]

**Martin:** *Sometimes, like I've been referred to a social worker, a number of times, and what they do, the psychiatrist writes to a social worker, and says look he needs help, he's blah blah blah, blah blah blah. And then you go and see them and they say, 'look he's' not ill enough', and then you're left to your own devices, sort of thing.*

#### 4.4 The importance of peer trainers and co-production

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Across both data sets (the questionnaire and focus groups) students expressed that having course facilitators who were sensitive to their individual needs was very important. Having peer facilitators, who themselves have experience of mental health problems, was seen as very important. In figure 7, below it can be seen that 96% (27 out of 28) students agreed that trainers were sensitive to individual needs, and a similar number (93%, see figure 8) agreed that it was very important to have a facilitator with lived experience of mental illness. While the first question does not directly assess the importance of lived experience, it relates to some of the reasons as to why lived experience was seen as important by students. This was explored in some more depth as part of the focus group sessions.

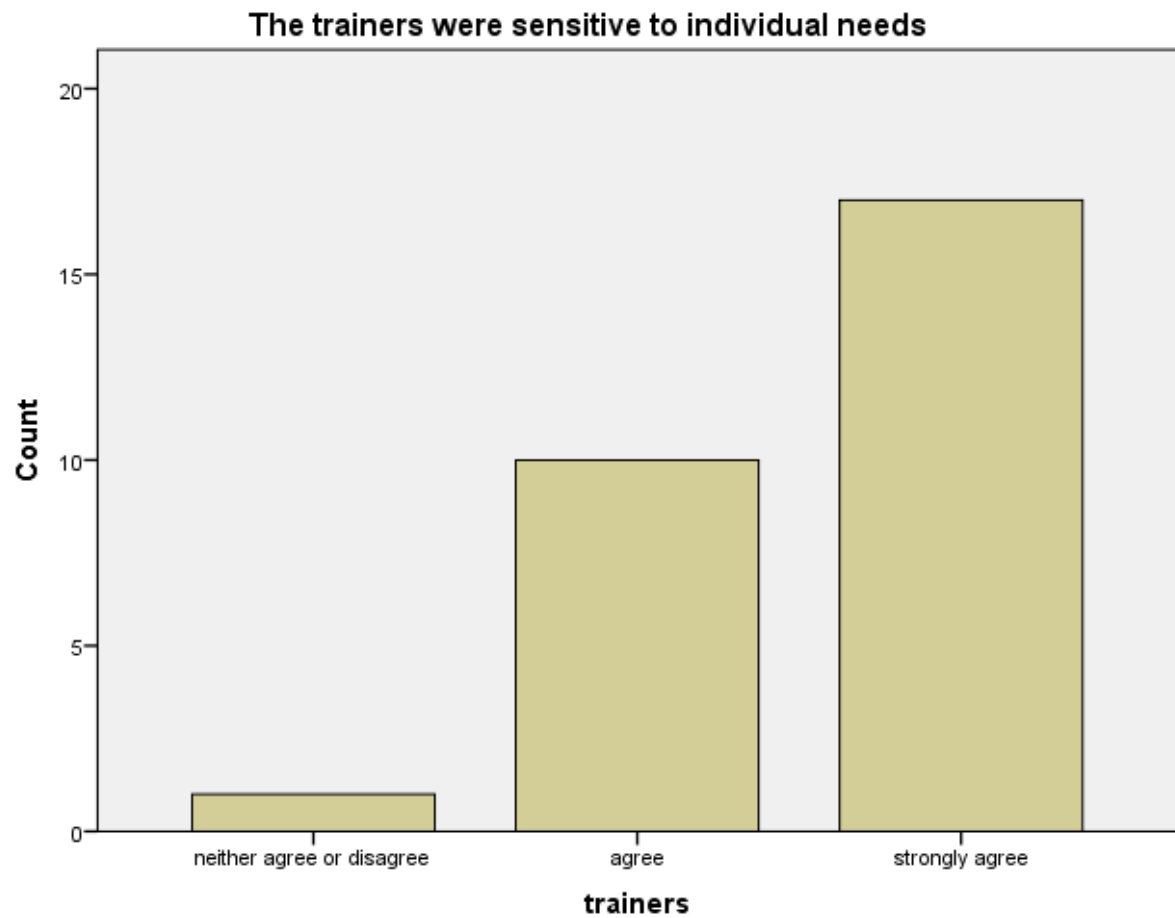
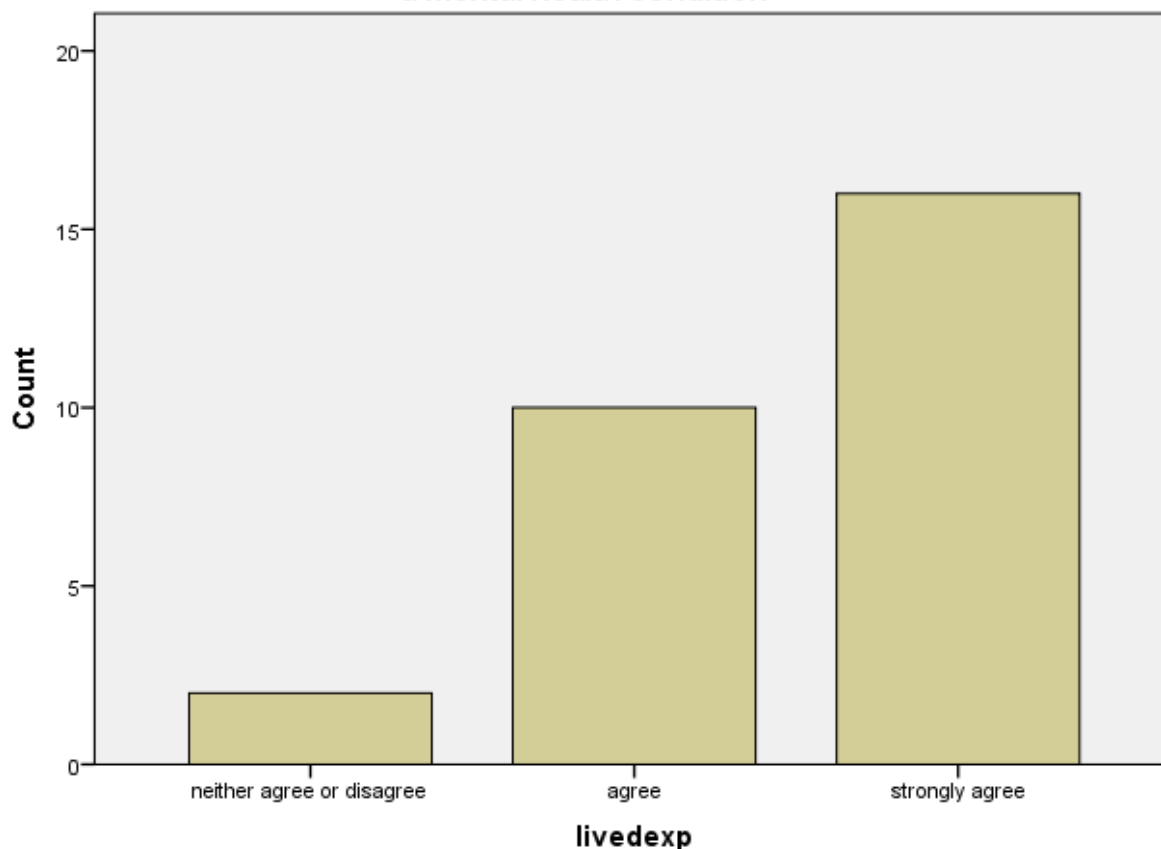


Figure 7. number of respondents who agreed that trainers were sensitive to individual needs

**It was very important for me that there was a trainer who had lived experience of a mental health condition**



**Figure 8. Number of respondents who agreed that it was very important to have lived experience trainer**

Participants across both focus groups highlighted that the use of peer facilitators was a particularly helpful aspect of the course, offering increased hope for the future and feelings of being able to give back, following the course. Indeed, as can be seen from Amy's excerpt below, peer support and lived experience was seen as *the* most helpful aspect of the course.

**Emma:** *What was the most helpful aspect of the course for you personally?...*

**Amy:** *I think mainly it was peer support, as well as facilitator support. So you know we we're all in the same boat. It was one big team. ...It was a whole journey for each of us, and they said they learnt from us as well and we'd learnt from them.*

....

**Obi:** *I think that's I think having the previous service user involvement, if you like, that they've done that journey does need to be highlighted more.*

**Lotus:** *The thing is for me, it's not just a therapy or something or other, for me it's an educational experience and I hope that in the future I am strong enough to put in some of my experience as well, not just learning all the time for these courses but able to maybe help others.*

In the quotes above it is apparent that having facilitators with lived experience was useful in that it removed barriers between facilitators and students and instead a sense that 'we're all in the same boat' (Leia). Peer facilitators were also seen by students as positive role models, and gave students the opportunity to consider how they may themselves give back and use their own experiences to help others (see Lotus, above).

#### 4.4.1. Providing adequate support and keeping lived experience at the centre of SERC development

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In the follow up interviews with peer facilitators, providing adequate support and training to develop and build confidence in the new role was emphasised. Peer facilitators reflected on how the change in identity from student to peer facilitator was challenging, and at times they felt 'thrown in the deep end' (See Sasha's quote below). However it was also seen as a personal achievement, rewarding and had increased personal confidence (see Misha's quote, below).

**Sasha:** *I'd like to, hopefully if they get the funding for Recovery College, I'd like to be employed as a peer support facilitator, with the training, to be trained as a formal role instead of an informal role straight from being a student without any extra training feeling a bit thrown in the deep end. But yeah, I'd like to carry on. I mean I'm sort of doing that as part drama I am doing, support leading a drama group, I am trustee of, progressing as part of that role.*

**Misha:** *Yes, we were rather "thrown into it". We had to learn as we went, and some training would be useful for ex-students or newcomers in the future. That said, it was*



*still a good experience to have in the main, it does show what service users & ex-service users can do.*

.....

**Sasha:** *Because we were ex-students, we weren't quite students, but we weren't quite facilitators in that we weren't qualified facilitators, so we had an OT, and uh, a Psychologist running the course, but we were mainly doing the facilitating, because we had lived experience.*

.....

As Sasha's quote above alludes to, a particular challenge for the peer facilitators was negotiating power dynamics in this role, when working alongside mental health professionals in developing and facilitating courses. Interviewees commented that the change in management structure had meant that the lived experience focus of the college in terms of co-production, diminished towards to end of the pilot program (see Sasha and Misha, below).

**Sasha:** *Right the change for me is the dynamics, in that BoBo [RC development lead], was a person with lived experience, of mental health, and it was widely known, he'd tell all the students when he spoke to them, um, so I'm not breaching any confidentiality there. Um, the difference in that, once he left um, the steering group was majority made up professionals, which was OTs, and so um the dynamics of that we kind of felt they were relying on us, and um, there was a couple of other people with lived experience.*

**Emma:** *As sort of reps, almost, you know?*

**Misha:** *Yes, this leads on to my point about the need to change direction somewhat. SEPT won't like this though they have done it (the second phase of the pilot) with a skeleton crew basically and in doing so, put a lot of emphasis on the volunteers which didn't make it easy for us. In future, it would be good to have a "team" of people with living (lived) experience of Mental Health conditions, there are a lot of good campaigners/activists out there. Also, a dedicated team of staff is needed to avoid the "skeleton crew" thing in the future.*

**Emma:** *What's been the impact of that?*

**Misha:** *Its]*

**Sasha:** *I think they lost um the lived experience key, which is the whole point of the recovery college. The team then was mainly professionals so they came with a professional view, so wouldn't have the lived experience view, although they had a couple of peer facilitators, lived experience got a little bit lost. Having ex-students on the team helped to put back the lived experience view.*

**Misha:** *Yes, the living (lived) experience aspect didn't seem "there" as much as it was in phase one of the RC pilot. They were focused on getting the second phase finished by a certain date. As a result, it did seem rather rushed. I do not believe projects like this should be rushed.*

## 5. Recommendations and Conclusion

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### 5.1. Summary of findings

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The summary of findings for each of the four components of the evaluation (see section 3) are provided below:

- 1) *The overall management and structure of the pilot program, its organisation and growth.* SERC failed to meet most of its set objectives and shows very poor performance when compared to successful colleges in other regions of the UK. However, three courses (across six deliveries) have been successfully developed and implemented, 50 students have enrolled, and a number of objectives have been met or partially fulfilled. Potential reasons for the delays and poor growth are discussed in section 4.1.3.
- 2) *The experiences of participating in the programme.* Findings across both questionnaires and focus groups were overwhelmingly positive. Importantly, the courses offered participants tools and new skills for the future, a sense of belonging, a way to meet others and make friendships. This was very important for overcoming anxieties associated with starting the course. Participants wanted a dedicated space to grow the college further, and enhance the sense of community that the college afforded.

- 3) *Changes over time following participation.* No significant difference in the recovery measure (QPR, Neil et al, 2008) before and after course completion was found. However, the majority of students reported feeling more hopeful for the future because of attending the SERC. Students also stated they had learnt new skills for the future, as a result of attending the course. This was supported by qualitative comments, both from the questionnaire, and focus groups.
- 4) *The impact of peer trainers and co-production on the process and outcomes.* Across both data sets (the questionnaire and focus groups) students expressed that having peer facilitators, who themselves have experience of mental health problems, was very important. In the questionnaire, 93% of students agreed that it was very important to have a facilitator with lived experience of mental illness. Participants across both focus groups highlighted that having facilitators with lived experience was useful because it removed barriers between facilitators and students. Peer facilitators were positive role models, giving students the opportunity to consider how they may themselves give back and use their own experiences to help others in the future.

## 5.2. Recommendations

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Below I propose six recommendations to help maintain the existing areas of success, and to encourage greater growth and future impact of SERC. These are based on the key findings from this evaluation as well as best practice guidelines published elsewhere (e.g. see Perkins et al, 2012; McGregor et al, 2014). These recommendations do provide suggestions for improvement, although it should be noted that SERC has already achieved progress against some of the proposed items (e.g. recommendations 1, 2, 4 and 5). These recommendations could guide further development of the college, and act as a benchmark to measure further development and the future success of SERC.

- 1) Ensure there is co-production between professional and personal experience of mental health problems at all levels and stages, including development, curriculum content and quality assurance. Co-production should be present in the facilitation of

all courses offered at the college, and done so in a meaningful and considered way, where lived experience of mental health problems is combined with professional expertise. While volunteering roles form part of the resourcing mix of most colleges, people with lived experience should also be recruited to paid roles in the college. Collaborations and consultation with other local organisations and services is also established and maintained (e.g. employability services, social care services etc.).

- 2) SERC complements, but is separate to, mainstream mental health services. It maintains its focus on offering an educational model for helping people to learn how better manage their problems and assisting personal recovery. It does not replace other traditional assessment and treatment offered within mental health services.
- 3) SERC has a physical location, offering students a central hub for the college, and a tangible commitment to the model (see Perkins et al, 2012, p. 5). The physical base can be used to offer courses, but also a place where people can come and continue independent learning (in the form of a library, for example). This is not to say that courses should not be offered in other locations in the region, but these are offered in addition to the resources provided at the physical base of the college.
- 4) SERC operates under college principles. For example, a prospectus of courses are offered, and a student charter details expectation of staff and students behaviour. Courses are not 'prescribed' but chosen by students, without influence from mainstream services. However, while it may offer opportunities and maintain links with relevant educational establishments locally, it does not substitute FE colleges, for example.
- 5) SERC continues to reflect recovery principles in all aspects of its culture and operation. Values of hope, empowerment, opportunity and choice are embedded throughout. It remains open to all (including carers, services users, and mental health professionals) and maintains a strengths based model, as oppose to considerations of deficit and cure / management.
- 6) Finally, establish a clear strategy for capacity building among the peer workforce. Offer support and training to peer support workers and peer trainers, and opportunities offered for people with lived experience to participate in staff

selection and training. By doing so, the college acknowledges the wider aim of promoting culture change within mental health services.

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# South Essex Recovery College

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## Recovery College Evaluation: 'After the course' questionnaire

### Section One: About You

First Name	
Second Name	
What is the name of the course you attended at The Recovery College	

### Section Two. Your experience of attending the course

Please tick the answer that best fits your feelings and views, following your attendance at the course.

The course content exceeded my expectations

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither Agree nor Disagree
- ☐ Agree
- ☐ Strongly Agree



I have learnt new skills, which will help me be able to do things I want to do in life, because of the course

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither Agree nor Disagree
- ☐ Agree
- ☐ Strongly Agree

The course has helped me set goals, which are reasonable and achievable

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree or disagree
- ☐ Agree
- ☐ Strongly Agree

The trainers were sensitive to individual needs

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither Agree nor Disagree
- ☐ Agree
- ☐ Strongly Agree

I feel more hopeful for the future, as a result of attending the course

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither Agree nor Disagree
- ☐ Agree
- ☐ Strongly Agree

The course content was delivered at the right pace

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither Agree nor Disagree
- ☐ Agree
- ☐ Strongly Agree

It was very important for me that there was a trainer who had lived experience of a mental health condition

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither Agree nor Disagree
- ☐ Agree
- ☐ Strongly Agree

The thing I enjoyed most about the course was..

The aspect I enjoyed least about the course was...

### Section Three: Questionnaire about the Process of Recovery

This questionnaire was developed to understand more about the process of recovery; what's helpful and what's not so helpful. Everyone is different and there will be differences for everyone. The items on this questionnaire were developed through a process of interviewing service users about their recovery journeys. Not all factors will be important to you, since everyone is different. **If you would like to fill in the questionnaire, please take a moment to consider and sum up how things stand for you at the present time, in particular over the last 7 days, with regards to your mental health and recovery.** Please respond to the following statements by putting a tick in the box which best describes your experience.

	Disagree strongly	Disagree	Neither agree nor disagree	Agree	Agree Strongly
1. I feel better about myself					
2. I feel able to take chances in life					
3. I am able to develop positive relationships with other people					
4. I feel part of society rather than isolated					
5. I am able to assert myself					
6. I feel that my life has a purpose					
7. My experiences have changed me for the better					
8. I have been able to come to terms with things that have happened to me in the past and move on with my life					
9. I am basically strongly motivated to get better					
10. I can recognise the positive things I have done					
11. I am able to understand myself better					
12. I can take charge of my life					
13. I can actively engage with life					
14. I can take control of aspects of my life					
15. I can find the time to do the things I enjoy					

## Appendix two – draft focus group schedule

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### SEPT Recovery College Evaluation

#### Draft Focus Group Topic Guide.

##### *Prior to attending the recovery college*

Course details

Student expectations prior to the course.

Example questions: Why did you decide to sign up for the course? How were you hoping to benefit from attending the course? Did you have any particular personal goals that you thought the course would help with?

How did you hear about The Recovery College?

##### *Student experience of the course.*

Subjective outcomes.

Example questions:

What has been the impact on you personally as a result attending the course? (Recovery and wellbeing – hope, control, opportunities, support, skills, activities, relationships)

What have you learnt as a result of attending the course?

Student experience and feedback

Example questions:

Did the course meet your expectations? Examples

What would you say was the most helpful aspect of the course? Examples

What was the least helpful/useful aspect of the course? Examples

What could be improved for the future?

Did the trainers respond to your individual needs?

Comments about trainers (peer trainers). Example question: Was it important to you that a trainer had lived experience receiving mental health services?

Are there any other comments you have about your experience of attending the course?

