Title: Developing a recovery college: A preliminary exercise in establishing regional readiness and community needs

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Abstract

Background: Recovery orientated intervention has experienced a paradigm shift towards stakeholder training and education within recovery colleges. Such colleges are typically underpinned by a culture of emancipatory education that aims to facilitate recovery through educational choice.

Aims: The study aims to establish regional readiness for a recovery college. Specifically, we aim to uncover key stakeholder attitudes towards recovery, outline a contextual conceptualization of recovery, and, show how inductive, community-based research can incorporate stakeholder views with core fidelity markers of a recovery college.

Method: A mixed methods approach, specifically a cross-sectional survey, was adopted to intersect quantitative scales of stakeholder attitudes, and, qualitative assessment of recovery concepts and community needs.

Results: Stakeholders' recovery attitudes were positive overall and mean scores for each participant group also indicated positive attitudes were common between groups with some variation. Concepts of recovery were developing independent abilities, establishing connectedness to support, and, as a journey. The needs cited by the stakeholders were largely correlated with the core fidelity markers of a recovery college.

Conclusion: A community psychology approach offers a means to ascertain regional readiness for a recovery college, and, uncover key development foci based on community needs. We recommend that service areas adopt a similar approach when considering recovery-orientated service developments.

Declaration of interest

None

Key words: Community Psychology, Mental-health, Recovery College

Introduction

The first UK based recovery college was established in 2009, within which students enrolled in courses to develop life-skills, and, an understanding of mental illness (Oh, 2013). By contrast to a hierarchical therapeutic model, the recovery college model propounds service-user agency through educational choice (Perkins, Repper, Rinaldi, & Brown, 2012; Onken, Craig, Ridgway, Ralph, & Cook, 2007) *similar to the development of recovery education centers and peer run recovery learning centers (Whitley & Siantz, 2012; Whitley, Strickler & Drake, 2011; Clay (2005); Hutchinson, 2011).* Evaluative success in facilitating sustained improvement outcomes in UK based recovery colleges has been established (Rinaldi, Marland & Wybourn, 2012). However, some have argued that there is a danger in adopting a 'one size fits all' approach to mental-health service provision and directly importing a recovery orientated model from one context to another (Rose, 2014; Turton, Demetriou, Boland, Gillard, Kavuma, et al., 2011). This research adopts a community psychology approach to indicate how to establish regional readiness and individualised college development plan. The intersection between quantitative scales of recovery attitudes, and, qualitative analysis of conceptions of recovery amongst key stakeholder groups will be discussed, along with a preliminary outline of community needs. Our aims are to indicate how regional readiness for a recovery college can be ascertained, to contextualise the meaning of recovery for key stakeholder groups, and, determine how well inductive findings will map on to existing fidelity markers of established recovery colleges.

Concepts of recovery

Recovery as an ideology has been present for more than a decade within mental-health. However, there is some contestation surrounding what constitutes a core conceptualisation of recovery. Anthony (1993) suggests recovery is "a deeply personal, unique process of changing one's attitudes… of living a satisfying, hopeful, and contributing life even with limitations caused by the illness… as one grows beyond the catastrophic effects of mental illness" (Anthony, 1993, p. 527). More recently, recovery has been conceived through comparison to a traditional medicalized model. Such contrasts indicate adopting a recovery orientated approach means being pro-health versus anti-disease, strengths versus treatment based, sees service-users as experts by experience in contrast to a doctor-patient hierarchy, and, that a transformation occurs within context rather than a de-contextualised return to normal (Roberts & Wolfson, 2004; Ralph, Lambert & Kidder, 2002; May, 2000).

Slade, Amering, & Oades (2008) suggest that recovery manifests through two central paradigms- that of 'clinical recovery' within professional literature, and, 'personal recovery' amongst consumer narratives (Slade, Amering, & Oades, 2008). The former conceptualises recovery in terms of treatment compliance, reduced remission and improved functioning, while the latter conceives of recovery the ability to make meaningful contributions within social life (Slade et al., 2008). The research suggests underlying contentions between service-user (consumer), and, service provider concepts of recovery, which may have important implications for developing recovery orientated services. It is contended here that a key means of incorporating stakeholder attitudes is through establishment of a recovery college.

What is a recovery college?

Perkins et al., (2012) outline five defining fidelity markers of a recovery college. They indicate that planning, development, and, decisions surrounding the college be developed through co-production (i.e. between stakeholders), that the college have a physical base- either a central building or a number of satellite locations; it operates on college principals (i.e. enrolment, module delivery etc.), that it is for everyone inclusive of service-users, staff, and the general public, and, that there be a personal tutor available to students to aid in course selection and/or student planning (Perkins et al., 2012). However, Oh (2013) notes an important distinction between traditional pedagogical paradigms that imbue the teacher with intellectual authority, and, the pedagogical model of recovery colleges, constituted by an ethos of 'emancipatory education' (Oh, 2013). Ultimately, the latter acknowledges the student as an active participant in their recovery through recognition of their lived-experience. Therefore, a recovery college is not a substitute for mainstream college or traditional assessment and intervention (Perkins et al., 2012). Rather, the college aims to complement existing services by facilitating service-user's active participation in their recovery, and, providing support to staff and community members through open enrolment.

Conceptual clarity in context

Researchers suggest that some of the contention surrounding recovery may have resulted from importing definitions such as Anthony's (1993), or, other de-contextualised conceptions of recovery to service or context communities where they have not been generated (Perkins & Slade, 2012). Hence, the ethos surrounding generation of our research has its roots in community psychology, with a view towards a broader contextual understanding of individual issues in a specific service provision context (Levine, 1998). By employing this research approach our overarching goal was to obtain an understanding of the dyadic between key stakeholders and

current structures of mental-health service provision in order to develop a college that can complement existing services, and, facilitate community members in engaging in a recovery process- essentially, to promote a shift in the culture of mental-health service provision through *participatory action research*.

Method

Sample

A heterogeneous sample (N = 254, Male = 61, Female = 189) responded to our survey about recovery attitudes, and, community needs; four people did not disclose their gender. Our service region is comprised of an urban region and two surrounding rural regions with a total population of 467,759 persons. *Participants were recruited by purposive sampling through peer centres, mental health services, mental health related services and local community centres with a 65% completion rate.* The urban region was disproportionally represented (N = 160) with the remaining coming from rural regions. *This reflects the concentration of mental health services in urban areas through many participants were recruited.* The largest age group of respondents was 36-50 years (N = 122), followed by those aged 26-35 years (N = 63), 51-65 years (N = 52), 18-25 years (N = 15), and those 66 years or older (N = 1). In terms of sample makeup, there were 55 members of the general public, followed by 47 service-users (currently engages in services), 42 staff members (providing mental-health services), 37 allied professionals (health-care staff not providing mental-health services), 26 family members of service-users, 18 friends of service-users, 17 those with experience of mental ill-health (not currently engaged in services), and, 11 volunteers.

Design

This was a cross-sectional survey study design. The survey was designed to contain a quantitative measure of recovery attitudes, and, open-ended questions to determine respondents'

concepts of recovery, to assess community needs, and, to uncover stakeholder considerations for developing a recovery college (for open-ended questions see Table.1). Surveys were produced via Unipark Questback survey development hardware and were distributed online to statutory and non-statutory service providers. Survey content was also transferred to hard-copy form and distributed to the above mentioned services and community groups to accommodate respondents with limited technological capacity (N= 36). Questionnaire data were inputted to SPSS 22.0 for statistical analysis. Open-ended responses were transcribed directly for both online and hard-copy submissions and analysed using content analysis (described below).

Process of implementation

All aspects of the survey were *developed in co-production with a research committee comprised of academics, staff involved in mental-health service provision, and, those with lived experience of the recovery process*. The Recovery Attitudes Questionnaire (RAQ-7) (Borkin, Steffen, Ensfield, Krzton, Wishnick, et al., 2000), developed through co-production within the Hamilton County Recovery Initiative in the United States was selected as the quantitative measure. The RAQ-7 contains 7 questions on a five point Likert scale that measures two recovery related factors, namely; that recovery is possible, (e.g. To recover requires faith) and, people differ in how the process manifests (e.g. People in recovery sometimes have setbacks) (Borkin, et al., 2000). RAQ-7 scores range from 1, strongly agree to 5, strongly disagree; thus, lower scores correspond with positive attitudes towards recovery. Analyses indicate acceptable internal consistency for both sub-scales and the total score (α coefficients .66, .64, and, .70) respectively, with good test-retest reliability (α coefficient .67), and, concurrent validity (Borkin, et al., 2000). *The RAQ-7 is considered appropriate to use with a wide range of individuals, as it*

was based on mental health consumers, professionals, family members, and representatives from the general population (Borkin et al., 2000).

Content analysis (Stemler, 2001) was selected as the means of analysis for qualitative responses as it allowed for generation of frequency data through inductive determination of community needs. After preliminary examination of the data, content was coded via emergent coding through development of a consolidated checklist, which was applied to independent coding (Haney, Russell, Gulek, & Fierros, 1998). Codes were developed as sampling units whereby meaning was attributed to key words and phrases (Stemler, 2001). Separately coded data samples indicated 95% comparative content, which suggested good reliability of coding (.8 Cohen's Kappa). Hence, full data coding was conducted by utilising the consolidated checklist. A final quality control check indicated reliability of comparative content within the full data coding process (Haney et al., 1998).

Results

Quantitative analysis and findings

Participants who completed the RAQ-7 (N = 246) had a mean score of 12.63 (*SD* = 3.71, range: 7-21), which falls between the strongly agree to agree range and corresponds with positive attitudes towards recovery. Mean scores for each participant group also fell within this range indicating positive attitudes were common between groups (see Table 1. for details on mean RAQ-7 scores per participant group)

A Shapiro-Wilk's test revealed that data were not normally distributed ($p = < .001$) and normal distribution was not achieved through log transformation. Thus, non-parametric tests were conducted. As the data satisfied the criteria for homogeneity $F (7, 238) = 2.05$, $p = > .05$, a

Kruskal-Wallis test was carried out to determine whether there were significant differences between RAQ-7 scores between participant groups. The test revealed significant differences between the groups X^2 (7, N = 246) = 15.31, p = .032, which explained 6.25% of variance in responses. Group differences were then compared via K independent samples tests. These tests revealed significant differences between service-users and allied professionals X^2 (1, N = 80) = 37.67, p = .006, with 9.71% variance, and, from those with experience of mental ill-health X^2 (1, N = 59) = 4.03, p = .045, with 6.95% variance. Staff members were also significantly different from allied professionals X^2 (1, N = 79) = 10.89, p = .001, with 13.96% variance, and, significantly different from those with experience of mental ill-health X^2 (1, N = 58) = 6.16, p = .01, with 10.81% variance, and, the general public X^2 (1, N = 97) = 5.13, p = .02, with 5.34% of variance.

Factor 1 (recovery is possible) analyses indicated significant differences between participant types X^2 (7, N = 246) = 24.82, p = .001, explaining 10.13% of variance. These differences were evident between service-users and allied professionals X^2 (1, N = 80) = 12.86, p = < .001, those with experience of mental ill-health X^2 (1, N = 59) = 4.99, p = .03, and, the general public X^2 (1, N = 98) = 7.26, p = .01. Staff members were different to allied professionals X^2 (1, N = 79) = 18.19, p = < .001, those with experience of mental ill-health X^2 (1, N = 58) = 6.67, p = .01, and, the general public X^2 (1, N = 97) = 9.41, p = .002. Volunteers were also significantly different to allied professionals X^2 (1, N = 47) = 5.13, p = .02. Service-users, staff members, and, volunteers had more positive attitudes on Factor 1 relative to the other groups. There were no significant differences between groups for Factor 2 (people differ in the difficult process of recovery) (see Table 2. for details on Factor 1 and 2 scores per participant group).

Responses did not vary by age, region or gender. However, recovery attitudes did significantly differ ($U = 21$, $p = .01$) between online ($N = 218$) and hard copy responses ($N = 28$). Hard-copy RAQ scores ($M = 12.81$, $SD = 3.22$) fell close to agree on average, while online respondents ($M = 11.25$, $SD = 2.37$) were closer to the midpoint between agree and strongly agree on average. However, given the small number of completed RAQ items from hard-copy respondents it is unclear if response method would have an effect on recovery attitudes in larger relative samples.

Qualitative Findings

One hundred and forty participants responded to the open-ended questions. Qualitative questions and text examples for all content codes are presented in Table 3. Results indicate 'Recovery' was viewed by 45% of respondents as an independent ability, by 33% as a journey- either towards change, or, a return to 'normal', and, by 24% as an accessing of support. Service-users, staff members, family members of service-users, and, the general public exhibited both views in their responses, whereas, those with experience of mental ill-health viewed recovery solely as a return to health. Recovery as an 'independent ability' was comprised of views that recovery was a development of a set of personal mechanisms, such as, coping, self-care, and, autonomous functioning. As a 'journey' recovery was constituted by a contention between the view that it was a process of returning to health from a medical illness or resumption of previous lifestyle ($N = 25$), versus, an ongoing process of change that results in permanent changes of self- or world-view ($N = 22$). Recovery as an 'accessing of support' related to recovery as an ability to engage with services, family, friends, and, society in general.

Training and education was viewed positively by respondents. Implicit in responses was a view that training and education would be delivered solely to service-users (48%), while 18% indicated training and education would be delivered to mental-health professionals. Specific responses indicated the role of training and education should be utilized for stigma reduction on mental ill-health were coping, practical skills and, service orientation. 'Coping' related to the view that training and education should promote internal resilience through self-care and management, while, 'practical skills' related to training of externally applicable abilities such as literacy, daily-living, employment, creative, and, physical skills. 'Service orientation' was comprised of preferences for the service to have a clear mission statement surrounding co-production.

The preferred location for delivery of recovery college courses was cited by 50% as all three regions (i.e. rural and urban locations), and, by 32% as the urban region. Twenty-five (18%) respondents indicated delivery should be in either rural region, a combination of two regions, or, nationally. Specified locations included university facilities in the urban region, local schools and community centres, and, within or in proximity to current mental-health services.

The top three concerns for delivery of recovery college courses were accessibility (29%), personnel (28%), and curriculum (21%). 'Accessibility' related to concerns about transport, discrete, central location, and, that courses should be open to staff, service-users, and, the general public. 'Personnel' was constituted by a contention between respondents' views that courses should be service-user versus multi-disciplinary professionally run. Nonetheless, the concern was also comprised of the view that courses should be developed and delivered in co-production. 'Curriculum' was comprised of concerns that courses should be varied, and, focus on practical

skills such as literacy, movement, creative arts, life skills as well as relaxation techniques, yoga, and, mindfulness classes.

Respondents' additional comments and suggestions indicated that the recovery college should be inclusive (17%), which was directly related to the 'accessibility' concern surrounding location, transport, and, public access. There were also several specific suggestions including; opening hours to facilitate working attendees, learning assistants for those with literacy issues, self-experienced facilitators, open-access cafeteria, and, a mobile unit to service all locations.

Discussion

A primary aim of our research was to determine regional readiness for establishment of a recovery college. *Analysis of the RAQ-7 indicates that there were significant differences between the participant groups in terms of recovery attitudes. Here we found that service users and staff members had lower attitude scores relative to the other groups. A similar pattern was found on Factor 1 scores surrounding the belief that recovery is possible. One reason why service users and staff members had lower attitude scores may be that they have more knowledge and direct experiences of the challenges faced by those with mental difficulties*. However, both collective RAQ-7 scores, and, Factor 1 scores were either positive or highly positive towards recovery. Factor 2 scores surrounding the belief that people differ in the difficult process of recovery were unified in the high positive range. Therefore, taken together the RAQ-7 findings indicate that establishment of a recovery orientated service should be well received as there is support of the recovery concept cross-regionally amongst key stakeholder groups. *It is also worth noting other studies have found the opposite to our findings reporting that service users and staff have the highest attitudes to recovery when compared to other group (Borkin et al; 2000). One reason for*

this could be the different health and social care contexts (United States and Ireland, private versus public systems of care).

Another aim of this study was to contextualize what recovery means for key stakeholders within a specific service provision context. The resulting conception of recovery draws upon personal, process, and, social aspects of recovery. Recovery as an independent ability is highly reflective of themes suggested by previous reviews such as a shift in power and control from a doctor-patient hierarchy towards service-user agency, and, a form of optimism surrounding the possibility of improved outcomes through the recovery process (Bonney, & Stickley, 2008). The view of recovery as a journey was reflective of contentions between 'clinical recovery' and 'personal recovery' (Slade et al., 2008). The clinical recovery, or, return to normal concept is indicative of a medicalized view of recovery as a return to health. Conversely, recovery as a journey was viewed in terms of transformation, which is more concordant with consumer narratives of 'personal recovery' (Slade et al., 2008). This form of journey is more in keeping with concepts of recovery that point towards personal transformation (Roberts & Wolfson, 2004; Ralph et al., 2002; May, 2000).

Such findings reflect an intersection between RAQ-7 findings that staff and service-users, who were more positive about recovery, viewed recovery as a journey towards change, whereas, those with experience of mental ill-health, who were had less positive attitudes about recovery in the RAQ-7 findings associated recovery with a more medicalized view of a return to health. Recovery as an accessing of support also links to recovery concepts that place transformation through recovery within the context that individual difficulties arise (Roberts & Wolfson, 2004; Ralph et al., 2002; May, 2000). Again, his view of recovery was shared predominantly by service-users, and, staff members who were most positive about recovery within RAQ analyses.

Another aim of our study was to determine how well our findings would fit with the necessary fidelity markers that have constituted recovery colleges in other areas. The five core fidelity markers are co-production in planning development, and implementation of the college, a physical base, open enrolment for all, and availability of personal tutors (Perkins et al., 2012). Of importance to our respondents in terms of training and education was a service orientation that facilitated co-production. Co-production was also an important feature of stakeholder concerns that there be strong service-user input and multi-disciplinary interaction in recovery college delivery. These findings correlate with the fidelity markers that the college should be developed and delivered through co-production, and, that there be advisors available to students, inclusive of professional and self-experienced advice. Another fidelity marker for a recovery college is that it should have a physical base- either a central building, or, a 'spoke-and-wheel' arrangement constituted by a central building and satellite locations. The largest proportion of responses indicated that the recovery college should be delivered throughout all three regions, a combination of two of the three regions, or nationally. Hence, our findings suggest that the former is most appropriate to our service context. A cross-regional base for the recovery college directly links with the need for accessibility, which was respondents' foremost concern about delivery of recovery college courses. However, almost half of responses suggested that training and education would be *specific* to service-user education *and predominantly* came from staff members and allied professionals. This view is contrary to 'open enrolment' principles of recovery colleges (Perkins et al., 2012) *which outlines that people with mental health problems, families, carers, staff from mental health service providers and people from partner agencies can all attend courses.* Hence, it is important within our region to develop our college in a way that promotes recovery based education for all stakeholders. *Findings suggest that fostering a greater*

understanding amongst mental health staff and allied professionals of the benefits of co-production, co-delivery and co-learning should be a priority in advance of the development of a recovery college.

Our findings also point towards a good understanding of stakeholders between mainstream colleges or services and a recovery college. Respondents were overwhelmingly in favour of recovery focused training and education towards applied skills such as literacy, numeracy, and, help with employment. This finding is concordant with the distinction between a traditional pedagogical paradigm, and, the paradigm of emancipatory education (Oh, 2013) such that the learning acquired by students focuses on improving lived-experience as opposed to courses of testable knowledge. Moreover, as one of the key concerns for respondents' was that the curriculum be focused on development of practical skills, there is further correlation with the distinction that a recovery college is not a substitute for mainstream college or existing services but rather acts to complement existing services (Perkins et al., 2012), and, enhance student agency in their recovery or recovery facilitation.

Conclusion

Our findings represent a corollary for previous research surrounding concepts of recovery, and, fidelity markers of existing recovery colleges. They suggest positive recovery attitudes, contextualised conceptions of recovery, and, preliminary assessment of community needs combine as positive markers for developmental readiness of our region for establishment of a recovery college in our region. The results also suggest important intersections between quantitative recovery attitudes recovery attitudes amongst those who were most positive

surrounding recovery and conceptions of recovery as a transformative journey, versus, those who were less positive about recovery and a more traditional medical view of recovery as a return to health. The needs cited by respondents are also largely reflective of the core fidelity markers of existing colleges. Hence, our main aims to establish regional readiness, contextualised concepts of recovery, and, inductive mapping of community needs to existing fidelity markers have been met.

Nonetheless, our findings suggest that not all stakeholders were of the view that enrolment within the college would be open for all. As this is converse to the existing fidelity marker of open enrolment, it will be important to develop and promote open enrolment for all stakeholders in order to meet inclusivity standards of established recovery colleges. Additionally, as the findings presented here relate to a preliminary exercise in establishing regional readiness and community needs, a limitation of this study is that aspects, such as specified curriculum development, or, allocation of college resources, are not fully developed. Therefore, it is important that researchers view this research as a preliminary exercise in establishing regional readiness and community needs. *In addition a second limitation is the use of a cross sectional survey design.* Consequently, we recommend that a preliminary exercise such as ours should form the initial phase in a three-phased needs assessment to include focus group and finally individual interview research to allow key stakeholders to specify a holistic recovery college development plan.

The research approach we have outlined indicates it is possible to utilise an inductive approach to form the basis of deduction from the existing evidence base towards generation of a new model to fit with structures within our service provision region. *This has important implications for funders and developers when planning and operating such a service particularly*

in the context of scarce resources and budget constraints. We hope that this research blueprint will allow others to develop a region specific college that will complement existing services within their respective regions, and, to facilitate all stakeholder groups in their roles surrounding the recovery process. Hence, adopting a community-based approach can enable generation of a unique paradigm for recovery college development within a specific context.

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Appendix

Table 1

Mean RAQ-7 Scores by Participant Type

Participant Type	**N**	***M***	***SD***	**Range**
All RAQ-7 scores	246	12.63	3.17	7-21
Service-user	43	11.79	2.94	7-17
Staff Member	42	11.48	2.81	7-18
Allied professional	37	13.70	2.56	8-19
Friend of a service-user	17	13.07	3.25	8-21
Family Member of a service-user	26	12.81	4.12	7-20
Experience of mental ill-health	16	13.69	2.75	8-18
Volunteer	10	12.40	2.95	8-18
General Public	55	12.98	3.32	7-19

Note: 7 = Strongly-Agree, 14 = Agree, 21 = Unsure, 28 = Disagree, 35 = Strongly-Disagree

Table 2

Mean RAQ-7 Scores for Factor 1 and 2 by Participant Type

Item	***M***	***SD***
Factor 1 RAQ-7 scores	**2.04**	**.62**
Service-user	1.81	.55
Staff member	1.77	.49
Allied professional	2.27	.42
Friend of a service-user	2.09	.57
Family member of a service-user	2.13	.8
Experience of mental ill-health	2.23	.63
Volunteer	1.95	.64
General public	2.18	.68
Factor 2 RAQ-7 scores	**1.49**	**.44**
Service-user	1.51	.46
Staff member	1.47	.38
Allied professional	1.54	.53
Friend of a service-user	1.57	.48
Family member of a service-user	1.42	.67
Experience of mental ill-health	1.58	.39
Volunteer	1.53	.42
General public	1.42	.36

Note: 1= Strongly-Agree, 2 = Agree, 3 = Unsure, 4 = Disagree, 5 = Strongly-Disagree

Table 3

Qualitative questions, content, and, coding samples

Question	Content	Coding sample
What is recovery?	Independent ability	*getting up each day*
		functioning to the best of their ability
	Journey	*get better from a short or long term illness*
		Versus
		Illness changes people…Recovery is ongoing *a learning curve*
	Accessing support	*'engage in family, social and employment*
What role do you think training and education has in the recovery process?	Service-user education	*'It gives people the skills and knowledge to manage their own mental-health*
	Professional training	*A great understanding with regards to mental-health*
	Stigma reduction	*Break down the stigma of poor mental-health*

Question	**Content**	**Coding sample**
If training and education was to be provided in a recovery college, what would you consider to be the most important topics?	Coping	*Self-Responsibility, coping skills*
	Practical skills	*Creative Arts, helping people with employment*
	Service orientation	*Friendly environment, shared goals*
What do you think would be most important to consider in developing a recovery college?	Accessibility	*Location, central, public accessibility*
	Personnel	*Collaboration, strong service-user input, multi-disciplinary involvement*
	Curriculum	*Reading, writing, including creative activities*
Comments and suggestions	Inclusivity	*Reaching out, include all services*
	Specified suggestions	*Provide buddy, book rental scheme, a mobile unit*