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Recovery Education College:

A Needs Analysis

Authors: Dr. Jennifer McMahon, Niamh Wallace, Joy Kelly

& Eithne Egan

Mid West ARI Project

Acknowledgements

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EXECUTIVE SUMMARY

This research was undertaken by the Recovery College subgroup of ARI Mid West. Its purpose was to determine the potential for and feasibility of introducing an education approach to recovery in mental health in the region. This project is the first step in realising the third ARI goal for the Mid West – *Establishing a Recovery College/Education Centre* and consists of a needs analysis of recovery education in the region.

Methods & Participants

This particular piece of research used interviews, focus groups, surveys and community consultations with identified stakeholders [service users, HSE staff, carers, HSE affiliated professionals and the general public] to establish the requirements of this particular region as to the structure, development and content of a Mid West Recovery College.

- 260 people responded to the survey component of this research.
- 20 people participated in the focus group component of this study
- 8 people participated in the one to one interview component of this study
- A series of 7 community consultations were conducted in urban and rural areas across the region

Key Findings

- A definition of recovery in mental health for the Mid West emerged which included the following key themes; 'independent ability', 'accessing other supports', 'return to normal' and 'process of change'. These concepts were developed to create a tailored definition of 'Recovery' for the Mid West region:

Mid West Region Definition of Recovery

> *'Recovery is an ongoing process and is not an end goal. It describes a person's journey towards independence, and embodies a belief that one has purpose and value with or without the symptoms of mental illhealth. It is made possible by the support and guidance of others but ultimately it is about making educated choices as an individual about how best to manage one's own well being and health'.*

- It is perceived that education has a key role in recovery as demonstrated in the following emergent themes; 'vital importance', 'stigma reduction', 'service-user education', 'staff education', and, 'practical skills'.

- The Mid West stakeholders desire specific content to be included in a recovery college/education service including: mental health education; health promoting activity; a social aspect and a broad range of resources.

- Survey results indicated that participants would like to see recovery college courses to be delivered in urban and rural areas in all three geographical locations

- Accessibility is identified as a vital factor in the delivery of a recovery education. This includes factors such as transport, opening hours and availability of staff.

- Participants indicated clear preferences for the structure and delivery of recovery education in the region including: co-production at every level; a clear governance structure; accessibility; availability to all (staff, service users, carers, public).

Key Recommendations

The research conducted indicates that stakeholders in the Mid West believe that education is a key component in achieving personal recovery and delivering a recovery oriented service. Based on the information obtained, the recovery college subcommittee recommend the following:

- The establishment of a clear governance structure to implement and manage the roll out of an education approach to recovery.

- A steering body to be appointed which includes representation from key community partners e.g. VEC, UL, LIT, NLN etc.

- The development of a strategic plan for the roll out of a recovery education service across the region.

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- A clear pathway of communication to be established with the National ARI team and links made with other areas of the country establishing similar models or approaches.

- Recovery education initiatives to commence on a phased pilot basis with a clear evaluation system built in.

- Co-produced recovery focused modules/workshops to be developed for all stakeholders.

- The encouragement and support of staff members in the mental health services to participate in recovery focused education. HSE mental health services management team to develop a strategy to release staff to attend, co-produce or co-deliver training/modules.

- The support of innovative strategies that enable service users to participate and benefit from recovery focused education

- The enhancement of links with partner organisations to ensure a collaborative and sustainable approach to the development of recovery education in the Mid West

- Continuous monitoring of module relevance and module content with special attention to recovery values

Conclusion

The findings of this report strongly support the development of a recovery approach to education in the Mid West region. The development of a Recovery College presents an opportunity to deliver a unified and integrated approach to recovery education that would complement existing mental health service provision and enhance individual recovery outcomes.

Introduction

Recovery is a personal journey of discovery (Repper & Perkins, 2012). It involves making sense of, and finding meaning in, what has happened; becoming an expert in your own self-care; building a new sense of self and purpose in life; discovering your own resourcefulness and possibilities and using these, and the resources available to you, to pursue your aspirations and goals. Advancing Recovery in Ireland (ARI) is an eighteen month initiative which is supporting seven HSE mental health services in their efforts to implement a number of the key concepts of "A Vision for Change", Irish mental health policy (2006). ARI focuses on service level structures, systems and practices that can maximise personal recovery, and on the development of recovery focussed practice in the service. It recognises the service user, service provider and carer as equal stakeholders in the process.

ARI is a Genio funded partnership between the Mayo Recovery Consortium, EVE, The Centre for Mental Health/NHS Confederation (UK) and the HSE. Mental Health Services throughout Ireland were offered the opportunity to take part in the initiative. Site readiness questionnaires were completed by interested services. From a total of 47 applications, seven were chosen to participate which included the mental health services of the Mid West (Limerick, Clare and North Tipperary).

As a chosen site the Mid West established a project group consisting of all stakeholders in the local mental health support system – senior management, service users, mental health professionals, families/carers and voluntary sector groups. This group was tasked with identifying three key organisational challenges that would become the focus of the work over the subsequent 15 to 18 months.

The Mid West chose the following three challenges:

- Supporting staff on their recovery journey
- Changing the culture of the organisation
- Development of a recovery education centre

This research examines the potential for and feasibility of introducing an education approach to recovery in mental health in the region, the third chosen goal of the Mid West

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ARI group. The aim of the study is to determine attitudes to recovery in the region in conjunction with identifying the need for recovery education as well as the regional factors to be considered in the development of such an initiative.

The research has been conducted on a voluntary basis and is itself an example of best practice in co production (a key recovery principle). Grounded in the values and ethics of recovery, this research was undertaken with input from all key stakeholders.   This report identifies the relevant literature, the goals and structure of Mid West ARI, outlines the methods of data collection, presents the findings and makes concrete recommendations for the development of recovery education in the region.

1.1   Reflections on Research Process

This research project adhered to the principles of co production, an underpinning value of the recovery ethos. Given the unique nature of such as process we considered that eliciting the thoughts of each member of the project group on the process would contribute to the overall impact of the project. The thoughts and feelings of each member on the process are presented.

Angie Lindenau

The idea of a Recovery College inspired me. When I was deeply depressed I had stumbled upon a workshop where I managed to solve a problem that nobody else could tackle – this gave me hope that my head was still 'usable'. It was my starting point for going back to learning, and I haven't stopped since.

This experience gave me self-confidence. It turned into a way of life: with the internet finding out useful information has become easy, and I have educated myself on many different health issues. But human contact is crucial, so I also explored several support groups where I found some helpful nuggets.

At that time Mental Health Services had medication to offer, which gradually was complemented by art therapy, mindfulness and relaxation courses. Coming across Le Chéile

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and Aras Folláin I saw opportunities for people 'doing it for themselves' with some initial support, and having fun with others in the same boat in the process.

Knowledge about a subject reveals its true value; when I meet somebody who is only just starting to look for answers – I may help them find where to start searching, maybe tell them about a book that is useful for their specific recovery road. All this made me want to get involved in the project and do my best to make it real. We kept our many meetings focused on the goal of creating a resource that is inclusive for all with an interest to take part. It fills me with pride that our group has walked the talk in 'co-production' mode and some of us found that working on the project was our route of recovery.

To ensure a sound foundation we asked all 'categories' of potential users for input into our groundbreaking research project about their concept of 'Recovery College'. This report presents our findings

Eithne Egan

I am a Senior Occupational Therapist in a Community Mental Health Team in Limerick City. I was asked to join the Recovery College subgroup in September 2013. Working in the group has been a highly valuable experience.

From the outset, it was obvious to me that group members shared a true passion for improving the availability/quality of services for people with mental health difficulties. I believe this unstated ethos was the basis for the group's unity, which I found very encouraging. Members' commitment and dedication were also clear, this was impressive and motivating. There was a high level of respect within the group. Members interacted throughout as individuals - not as services users, carers or health professionals. The term "co-production" was unnecssary. This to me was quite remarkable and promoted my continued involvement. Issues were discussed throughout the process without the overall purpose of the group being obscured.   A tandem valuable aspect of working on the project was the opportunity to meet with members of the public and discuss their ideas for a potential new service in the area. Hearing the views of people outside of the mental health service was refreshing and very beneficial for the project.

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Challenges of working in the group included some absenteeism from meetings a lack of feedback on agreed tasks. These delayed the project substantially unfortunately, and stood in contrast to the otherwise strong community spirit described above. A further notable challenge for me was a lack of clear structure/governance in the ARI project as a whole. Measurable outcomes for various groups were not identified, this lead to confusion. I found the interplay between the roles/priorities of the different groups involved distracting and at times discouraging. Also, an overlap between evident outcomes for other regional goals, and those for the recovery college subgroup was identified towards the end of the project; this was confusing for me and served at times as a focal point for stress.

Overall, I found being involved in the project very positive. It has been a huge learning experience for me and I value greatly the work the group has done. The process in itself was uniquely gratifying. Working with people of this level of commitment and integrity has been a genuine pleasure. My experience over the last 10 months is likely to bring positive changes in both my personal and professional life. I am very glad to have had the opportunity to be involved.

Elaine Cunniffe

I am a Development Officer for Mental Health Ireland for Clare and North Tipperary. As a Development Officer for Mental Health Ireland I believe being involved in the Recovery College Committee for ARI can be a tool for change. I was motivated to be involved because I feel opening a Recovery College could help so many people. The idea of carers, family members, professionals and those with lived experience learning beside and from each other is inspiring, and is something I hope will come to fruition.

Being a committee member of the Recovery College Committee allowed me to speak to carers, service users and professionals on the ground about mental health and how services could be improved. This in itself was a positive learning point for me as some of the issues raised by these groups were issues and points I had not considered before. The focus group and information sessions I was involved in showed me that a Recovery College can be for

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everyone, offering a diverse range of classes and supports empowering people to be proactive in looking after their own mental health and overall wellness.

Being involved in this committee was a pleasure as I work alongside individuals from different organisations and communities. The Recovery College Committee worked so well because everyone felt their opinion was valued and respected. I believe myself and other Mental Health Ireland Development Officers could be involved in the future to promote and signpost the Recovery College in our work.

Gerard Collins

I will start by saying a bit about myself. My name is Gerard Collins. I come from a big family. I was working since I was 10 years of age. Things were different in those days, because there wasn't much money around. So you had to work hard and get some money, so you could eat, and help your Mother out with the upkeep of the house. So I didn't get much schooling. But I was a good worker and that stood to me in life, and I had a lot of respect for other people, so that also stood to me. Now I will tell you how I got to know about the recovery college committee. I had a bit of a breakdown, so I spent some time in ward 5B at University Hospital Limerick. So as I was there, I met Eithne Egan. She was part of the staff to help people like myself, to feel good about themselves.

The first meeting I went to, I didn't know what to think, because this was all new to me. The people on it were all kind of different towards what I would be used to talking to. But as I went to some more of the meetings, I began to understand more of what they were trying to achieve. And of course I had my say at the meetings, and it was good that someone was listening to my opinion. That's all anyone wants in life, is someone to be there and listen to them and value them and make them feel like they're part of something. Now I had a big problem at first at the meetings because my reading and writing wasn't so good. But I addressed that problem by going back to school. So that was all down to being part of the recovery college meetings, that I am feeling so good about myself and everything else around me. So I will stop now and say thank you to everyone on the recovery college committee for getting me back my life. And that's the truth.

God Bless.

Liam Morrisey

My name is Liam and I was at the very first meeting of ARI in the Mid West and was impressed with what I heard. After the meeting I was asked if I would join the recovery college subcommittee and I jumped at the opportunity. My interests were in particular in rural isolation, availability of services and how people access services and information. We had regular fortnightly meetings with 100% attendance at all meetings, making regular progress with everyone's involvement. We organised and travelled to Mayo to see the set up there which was helpful to us to see their progress and pitfalls. I was involved with the roadshow presentations and the interviews with service users, carers and professionals in Clare. This showed clearly to me the problems and concerns that service users have in relation to availability of services. This was particularly clear in rural areas. I also attended numerous national learning sets with contributions from UK Imhroc team.

I felt the recovery college committee worked very well as a group. The amount of work completed in a short time by a voluntary committee was outstanding. I felt I was there from the start to the finish and would love to be involved in some way in the recovery college project in the future and feel proud of what was achieved.

Joy Kelly

Working as part of the ARI research sub-committee on developing a recovery college in the Mid-West region has been an extremely rewarding experience. My previous research has focused on promotion of organizational change within Irish mental health services with a recovery focus. However, the shared decision making process throughout my research experience with ARI has been a novel means of generating, developing, and producing a piece of research that truly acknowledges the collective opinion of key stakeholders at every level.

The ethos of co-production on the committee presented it's own set of challenges, and there were clear contentions on how best to develop the recovery college throughout each phase. Nonetheless, without these there would have been no process of growth. For my part, working with the professionals and those with lived experience on the committee has significantly enriched my competencies and views on how recovery can be promoted in

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professional practice, for those engaged in a recovery process, and for the community within which change occurs.

It is my hope that the resulting research will inform development of a recovery college in the region and act as an example of how macro level change is possible through inductive, community based research for integration of a holistic model of service provision for mental health.

Linda Power Hogan

My name is Linda Power Hogan and my occupation is that of a Development Officer in the areas of Limerick City and County for Mental Health Ireland. Mental Health Ireland is a national voluntary organisation which aims to promote positive mental health and to actively support persons with a mental illness, their families and carers by identifying their needs and advocating their rights. As part of my role I attended and was part of the Recovery College Committee. The reason for my involvement with the Recovery College Committee was due to its premise encompassing all of Mental Health Ireland's aims. It aims to promote positive mental health in service users by encouraging them to educate and equip themselves with the tools to promote their well-being. Through education, its premise thus supports service users, their families and carers by identifying their needs and fulfilling them. I wanted to be involved in the Recovery College Project as it is an exciting and innovative way in enabling service users to help themselves.

My experience of the committee was that of a very positive one. The dynamics of the committee was that of both service users and service professionals. This working dynamic was healthy, respectful, enthusiastic and committed with a willingness to resolve any problems that may have been encountered. The working committee could therefore be referenced to the future success of the Recovery College with both service users and service professionals working together both competently and professionally. My involvement in the committee gave me hope that new and exciting developments are underway to help service users in the long-term. Instead of resolving mental health problems short-term the Recovery College can offer long-term benefits of: education, well-being tools, support, relationships, sense of achievement, sense of being and belonging, the list is endless. I am

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very grateful to have been involved in such an enthusiastic dynamic group and would be willing to be involved in any role with the project in the future.

Niamh Wallace

I am a senior occupational therapist working in the mental health services in the mid west for the past 13 years. I have been involved with the recovery college committee since August 2013. As someone who works in the service I found the initial ARI experience exciting but somewhat daunting.   It was difficult to envisage how the large regional group involved could work together to facilitate change.

It is for this reason that I became involved initially in the recovery college committee. It appeared that there was potential for an inclusive and clear approach to achieving this particular ARI goal.   I have always been involved in working closely with service users, in consumer panel, in co-delivering lectures in UL or simply setting up feedback loops when I worked in the Rehab service. I am also very interested in the power of education and how this can transform people's lives and was interested to explore its potential in recovery in mental health.

Working with the recovery college group was motivating and enlightening on many different levels. From the outset there was a strong ethos of equality which never needed to be defined or ascribed. Input from service users, carers, voluntary bodies and mental health professionals held equal weighting at all times. "Co-production" was a given, again without the group having to be definitive in their actions. The skills of the group members were utilised to excellent effect with many opportunities to share and learn from each other.

Within the group I discovered a passion and appetite for change that was positive and exciting. This was mirrored in our interactions with the people we met in the process of the research. The importance of inclusion and simply asking people what they need has been highlighted continuously.

Overall, the experience of working with this group has been highly valuable for me and is an excellent example of how effective "working together" can be.

Jennifer McMahon

I am lecturer and researcher at the University of Limerick in the area of psychology and education with a long standing interest in mental health issues. I currently serve as the Chairperson of the Limerick Mental Health Association and became involved in ARI through work on mental health recovery that I had been involved in over a number of years. I am passionate about the power of education to transform lives and on joining the group I felt that I could best support the goals of the ARI group through employing my research skills to assist in the challenge of developing recovery education in the area. I am a strong believer in the uniqueness of each individual accessing mental health services and the distinct environments that such services operate in. As such I felt that a needs analysis of the area would be extremely beneficial in informing any work in this area.

I feel extremely fortunate to have worked on the recovery education subgroup. It has been my privilege to work with a group of people who are so passionate about improving the mental health services for all involved. The contribution of each member was invaluable and together we created an atmosphere of respect, support and value for each other. Co-production is not without its challenges but staying the course has reminded me that a small group of people can indeed achieve great things. This research study is a testament to that.

It is my hope that each individual involved in the mental health services has the opportunity to experience the positive aspects of 'working together' and that this research study acts as a catalyst for transforming the services vision for change into a reality in the Mid West region.

2.   Brief Literature Review

Approaches to service delivery for people with mental health difficulties have been evolving over the past number of decades. Dissatisfaction with the traditional medical model approach to treatment and intervention, in systems that focus on a maintenance model of care, has become increasingly evident in society (Turner, 2002). Following on from progress within the physical disability movement and the move to deinstitutionalisation within psychiatry, a recovery approach to mental health emerged in the United States in the 1990's. Since then recovery, as both a movement and a philosophy, has been adopted and built upon in the UK and more recently in Ireland. Whilst services in Ireland have been incorporating elements of a recovery ethos for some time the Heath Service Executive of Ireland has been actively pursuing a reorienting towards a bio psychosocial model since 2006 that incorporates the ideals and values of a recovery approach to mental health difficulties. The landmark policy document *A Vision for Change* (DoHC, 2006) is a roadmap to achieving a service that is flexible and responsive to individual needs providing support within a holistic framework that emphasises a collaborative effort between the service and the service user. The policy emphasises the importance of education for all stakeholders in the mental health service as a means of developing resilience and well being in individuals as well as learning to cope with difficulties arising from mental health difficulties.

2.1   Recovery and Mental Health

Recovery in mental health is a multi-faceted concept and there are a wealth of meanings and definitions in use. Divergent views regarding the notion of 'recovery' have at times caused confusion and ambiguity. Davidson (2005) relates this confusion to the diverse ways the concept has been used; as an approach, a model, a philosophy, a paradigm, a movement, a vision and an illusion. From an individual perspective, the concept of recovery can have many meanings. Traditionally 'recovery' is associated with amelioration of symptoms whilst more recently 'recovery' reflects a broader perspective. For example Anthony (1993) noted that while mental illness may not be 'cured', the process of recovery means that the person with mental illness can still achieve 'wellness'. From this perspective recovery involves:

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'a deeply personal, unique process of changing one's own attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness' (Anthony, 1993, p.15).

Deegan (1988) defined recovery as 'a process, a way of life, an attitude and a way of approaching the day's challenges'. Similarly others define recovery as a process that involves gaining or regaining aspects of life otherwise taken for granted, that may have been lost or severely compromised by mental illness (Ralph et al, 2002, Allot et al, 2003 in Roberts & Wolfson, 2004). Bonny and Stickley (2008) analysed the recovery literature (170 papers) to distil the multiple definitions of recovery into core elements. Table 2.1 outlines the six broad themes indentified.

Table 2.1 Bonny and Stickley's (2008) universal recovery definition

Universal Recovery Definition	
Theme	**Explanation**
Identity	Can mean a focus on retaining one's identity and accepting and integrating an illness into one's sense of self. Can also be seeing recovery as needing to reconstruct a sense of who you are in light of experiences. Incorporates personal growth, healing and reclamation of a fulfilling, meaningful and satisfying life with or without symptoms.
Service Provision Agenda	Demonstrates the process of recovery from the person being 'dependent/unaware' to 'dependent/aware', independent/aware' and ultimately 'interdependent/aware'. A move away from the current statutory maintenance and relapse prevention model.
The Social Domain	Recovery is described in terms of accessing mainstream facilities and activities and gaining a social identity as people re-integrate into mainstream leisure and work opportunities and are potentially able to move away from being labelled. Also described as recovering a place of equality in society.
Power and Control	Refers to a transformation of services that means placing real power with service users. Self-responsibility and self-management are key aspects of the recovery philosophy but should not be the prescription of professionals but be achieved by the genuine empowerment of individuals. Choice is emphasised but some warn against tokenism where service users have the appearance of representation but lack any real power,
Hope and Optimism	Hope is a key ingredient to recovery and should be at the heart of all recovery and mental health discourse. A belief in ones ability to recover is thought to be instrumental to recovery and necessary to lead a fulfilling life with mental health problems.
Risk and Responsibility	Recovery is about potential and expectation, not the lowest common denominator of keeping everyone safe, taking no risks for failure. Staff should aim to do only what's absolutely necessary to assist a person meeting his or her needs to avoid fostering dependence

2.2   Background to Recovery Colleges

It is widely recognised that education plays a fundamental role in social mobility and that the benefits of education are numerous for both individuals and broader society. In response to the challenge of supporting mental health services to assist individuals in their recovery journey, Ashcraft and Anthony (2000) used an educational paradigm to drive recovery focused organisational and individual change.

> 'We decided to use education as the model for approaching recovery, rather than develop more traditional alternatives. We did this because we want our centre to be about reinforcing and developing people's strengths rather than adding to the attention on what is wrong with them, The guiding vision we had for the recovery Education Centre is reflected in the mission statement: people will discover who they are, learn skills and tools to promote recovery, find out what they can be, and realise the unique contribution they have to offer' (Ashcraft, 2000 in Perkins, Repper, Rinaldi & Brown, p.2)

Recovery Education Centres or "Recovery Colleges" have been central to the development of recovery-focused services in the USA. Examples include Boston, Massachusetts and Phoenix, Arizona. Centres have also been established in the UK including the South West London Recovery College and the Nottingham Recovery College. While Recovery Colleges may vary in design and implementation, they rest on eight defining features:

1. Co-production between people with personal and professional   experience of mental health problems
2. There is a physical base (building) with classrooms and a library where people can do their own research
3. It operates on college principles
4. It is for everyone
5. There is a Personal Tutor (or equivalent) who offers information, advice and guidance
6. The College is not a substitute for traditional assessment and treatment
7. It is not a substitute for mainstream colleges
8. It must reflect recovery principles in all aspects of its culture and operation

Perkins et al. (2012) outline a number of strengths associated with an educational approach to recovery.   They note that this approach has significant transformative power not only in assisting individuals in their personal and collective journeys of recovery, but also in assisting organisations and services to become more recovery focused. Recovery Colleges drive this transformation in a number of ways:

1. They enable people to become experts in their own self-care and develop the skills they need for living and working.
2. They explicitly recognise the expertise of mental health professionals and the expertise of lived experience in a process of 'co-production'.
3. They break down barriers between 'them' and 'us' that perpetuate stigma and exclusion.
4. They provide peer support
5. Group learning and mutual support replaces the disabling isolation engendered by a sole reliance on individual work
6. They afford choice, control and self-determination
7. They promote participation in the local community

Given that recovery education centres/ recovery colleges are still in their infancy evidence of the influence of education in recovery is limited. However, early research indicates that they are highly valued by those who use them (Rinaldi, Wybourn & Clenahan, in press).   In this study, the majority (68%) of participants at the South West London Recovery College felt more hopeful for the future than when they started their course; most (81%) had developed their own plan for managing their problems and staying well whilst 71% had become mainstream students, gained employment or become a volunteer. Findings also suggest that those who attended more than 70% of their scheduled sessions showed a significant reduction in use of community mental health services than those who did not attend courses.

Research was also conducted with staff one year after the establishment of the South West London Recovery College. Rinaldi and Suleman (2012) found that the majority (61%) of care co-ordinators in community mental health teams reported that people on their caseload had attended the College. They considered that students had benefited greatly from their

attendance. Care coordinators who had supported people to use the College also placed a higher value on service user self-management. These coordinators were more comfortable in supporting people and had higher expectations than care coordinators who had no one on their caseload attending the college.

2.3   The Present Study

The present research was initiated by the recovery college subgroup of Mid West ARI. This was considered the most effective initial step in achieving the chosen goal of developing a Recovery College/Education Centre. This was based on the rationale that there has not been a comprehensive review of recovery attitudes/needs across the region to date. There was also a notable lack of well designed co produced and co delivered programmes to support staff, service users and other key stakeholders to develop an understanding of recovery principles.

While ARI Mid West is working closely with Nottingham Recovery College who are providing advice and guidance to the current project, replicating their model would be insufficient to meet the needs of the stakeholders of the Mid West. Each geographical area represents a distinctive and unique set of people and factors that must be considered in the development and implementation of any initiative. It was decided that initial research would focus on determining the attitudes of key stakeholders in the region towards recovery and eliciting their ideas in relation to the development of a recovery education centre/recovery college.

3.   Background

Advancing Recovery in Ireland (ARI) is an eighteen month initiative which is supporting seven mental health services in their efforts to implement a number of the key concepts of "A Vision for Change", Irish mental health policy (2006). ARI focuses on service level structures, systems and practices that can maximise personal recovery and on the development of recovery focussed mental health practice in the service. As previously noted ARI is a Genio funded partnership between the Mayo Recovery Consortium, EVE, The Centre for Mental Health/NHS Confederation (UK) and the HSE.

As a chosen site the Mid West (Limerick, Clare and North Tipperary) established a project group consisting of all stakeholders in the local mental health support system – senior management, service users, mental health professionals, families/carers and voluntary sector groups. The group was tasked with identifying three key organisational challenges that would become the focus of the work over the following 15 to 18 months. Fig 3.1 outlines the ARI organisational chart and the relationship with the recovery college subgroup.

Fig. 3.1. Diagram of the ARI organisational chart
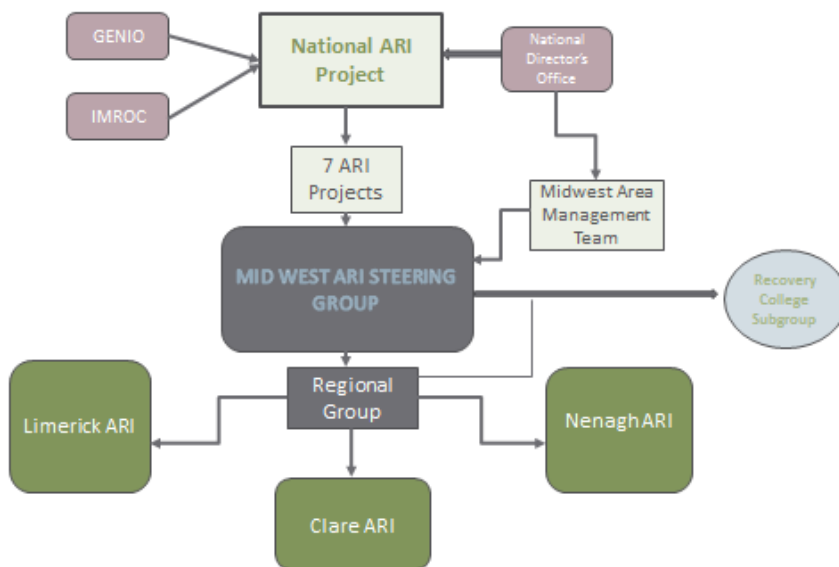
3.1   Organisational Change – Imhroc Methodology

The Sainsbury Centre for Mental Health (UK) developed a framework for organisational change in mental health services in 2009. This was based on extensive research with all stakeholders in the mental health system in the UK. The outcome was the report "A methodology for organisational change"(2009) which outlines ten key challenges that services need to address to achieve recovery oriented service delivery. At national level, ARI employed the services of the Sainsbury team as consultants for the Irish project.

A series of national learning sets were organised over the 18 month period. These were facilitated by the UK consultants and lead by Geoff Shepherd and Julie Repper. The learning sets took workshop format in which representatives from each of the seven ARI sites participated. Topics included peer support, recovery education and carer support. The UK consultants also facilitated planning meetings with HSE senior management teams in each of the ARI sites, and met with individual sites halfway through the project to offer feedback on progress to date. They were particularly complimentary of the research approach to recovery education of the Mid West group. Members of ARI Mid West availed of an opportunity to visit Nottingham Recovery College in November 2013. A representative of the Recovery College subgroup participated in this visit.

3.2   Mid West ARI Project Goals

The Mid West chose the following three challenges:

- Supporting staff on their recovery journey

- Changing the culture of the organisation

- Development of a recovery education centre

3.3 Community Profile

The Mid West mental health service
delivery area comprises the counties of
Limerick, Clare and North Tipperary.
The Mid West is a relatively diverse
region. The Limerick/Ennis/Shannon
triangle is an area of strong urban
growth. However, the region also
contains a number of rural areas with
significant population decline, such as
the West Clare seaboard and parts of
West Limerick.

This wide ranging demographic poses
challenges in any new development
aiming to meet stakeholder needs
across the region. The details below
highlight the key demographic factors
that may influence service provision.

Table 3.1. Population of Mid West region based on 2013 Centre for Statistics office (CSO)

Population Mid West Region			
Area	**Population**	**Male**	**Female**
Clare	117,196	58,298	58,898
Limerick City	57,106	27,947	29,159
Limerick County	134,703	67,868	66,835
North Tipperary	70,322	35,340	34,982
Mid West Region	**379,327**	**189,453**	**189,874**

Key Demographic Details

- The number of females in the region slightly outnumbers that of males.

- The Mid West Regional Planning Guidelines (RPGs) projected findings show that Limerick County will continue to expand its settlement population in the future with a target of 147,081 people by 2016, with County Clare expected to see similar population increases in percentage terms at 131,321 by 2016.

- The Region has a Youth Dependency rate of 30.2% (ranked fourth highest) and an Elderly Dependency rate of 17.0% (ranked fifth highest) out of eight Regions. Both ratios are slightly above the national average.

- The Region has an extremely favourable age structure with 21% of the population under the age of 15, 42% under the age of 30 and 71% under the age of 50. The average age of the Mid West population is 35.9 years which mirrors the national average of 35.4 years.

- There is a difficulty in retaining the Mid West population in the 20-24 and 25-29 age cohorts, particularly when compared to State average percentage in the same age groups.

- The Census 2011 statistics show that the majority of population growth in the Region has been focused in the Limerick-Shannon/Ennis areas

- The Census 2011 statistics show that transport in rural areas are poor and the majority of people travel by car.

Mental Health Resources

The region has a number of mental health resources comprised of statutory and non-statutory services. These services for adults include:

HSE Adult Services

In the Mid West there are eleven sectors comprised of 13 community mental health teams which are based in community mental health centres/day hospitals. The region has a number of specialist mental health teams including rehabilitation services, psychiatry of older persons, liaison psychiatry (including out of hours crisis service) and forensic services.

There are five in-patient approved centres in the Mid West. These are; Acute Psychiatric Unit, University Hospital Limerick (50 bedded unit on completion of redevelopment project); Acute Psychiatric Unit, Ennis General Hospital (39 bedded unit); Aurora Ward, St. Joseph's Pychiatric Hospital Limerick (1 ward remaining, 8 patients residing, due for closure end 2014); Tearmann Ward, St. Camillus' Hospital, Limerick (21 bedded unit – Psychiatry of Older Persons) and Cappahard Lodge, Ennis (34 bedded unit – Psychiatry of Older Persons/Rehabilitation).

HSE Community Residential Facilities

There are 11 high support community residences, 10 medium support residences and 7 low support residences across the Mid West Mental Health Services. These residences are managed by the rehabilitation services. The services across the region work closely with voluntary housing associations to ensure independent accommodation and security of tenure for mental health service users.

Adult Counselling Service

This service aims to help adults who have experienced abuse, neglect or trauma in their childhood to cope better in the their lives and relationships, now and into the future.

Suicide Prevention

This office is based in Limerick. Its function is to oversee the implementation of the National Strategy for Action on Suicide Prevention. The office also co-ordinate suicide prevention efforts in the region through liaison with agencies and individuals interested and active in suicide prevention

Some of the voluntary mental health organisations active in the Mid West region include:

Service	Type of Service
The Samaritans 20 Barrington St., Limerick	Crisis helpline
Pieta House Mungret, Co. Limerick	Counselling services for those at risk of suicide or self harm
Mental Health Ireland	Active throughout the region with a number of associations – supporting statutory services, promoting mental health awareness. Two development officers in the region
SHINE	Support and advocacy for families and individuals across the region
CARI Ennis Rd., Limerick	Sexual Abuse
GROW Henry street Limerick	Peer support, active across the region
Le Cheile Limerick Mental Health Association 3 Sexton St., Limk	Peer Support
Aras Follain Nenagh, Co. Tipperary	Peer Support
Emotions Ennis, Co. Clare	Peer Support
Mid West Rape Crisis Centre Rocheville House, Punch's Cross Limerick	Sexual Abuse
AWARE	Emotional Support
Living Links Limerick, Clare and Tipperary	Support for those bereaved by suicide
Console New Street, Limerick	Ongoing support for those bereaved by suicide

3.4   Target Group

For the purposes of this study the research target group was identified as mental health services users, HSE staff , carers and the general public.

4.   Methodology

4.1   Design Rationale and Summary

Purpose of the research

A research study examining the particular contextual factors in developing a Recovery College in the Mid West region was deemed important for a range of reasons. Although Recovery Colleges/Education Centres are well developed across the UK and the US, there is limited research available on their development and implementation. As with any community initiative, a wide variety of contextual factors need to be considered in tailoring a service to the unique aspects of the community. This piece of research aimed to determine the needs of the local community in relation to recovery focused education. Attitudes to recovery were ascertained in the process.

Research Approach

Whilst there are a variety of mechanisms for obtaining feedback and data with regards to the development of a community initiative, this specific piece of research was conducted by means of a mixed methods approach that would obtain a wide range of stakeholder's views as possible.

Broad Research Questions

The broad research questions that the evaluation addressed were:

- What are key stakeholders attitudes to recovery?
- What is key stakeholders understanding of recovery
- What are the factors to be considered In the development of a Recovery College?

Specific Research Questions

The specific research questions that the research addressed were:

- How do key stakeholders view the importance of recovery education?
- Where do stakeholders feel that recovery education should be available?
- How do stakeholders feel that a recovery college should be developed?
- What are the most important topics to be considered in the development of a recovery college curriculum?

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4.2   Research Methods

The methods used to collect data and answer the research questions included:

- A survey of quantative design with a number of qualitative questions
- 3 focus groups wth service users, staff members and family members/carers
- 8 one to one interviews with service users, staff members and family members/cares (drawn from across each area of the Mid West; Limerick, Clare & Tipperary)
- 7 community consultations across Limerick, Clare & Tipperary

4.3   Instrumentation

Survey

Researchers developed the Recovery College Questionnaire (see Appendix I) in order to elicit opinions in relation to Recovery and a Recovery College. The questionnaire consists of three sections:

Section 1:   Asks for personal details such as gender, age and relationship to the mental health services.

Section 2:   Examines the attitudes to recovery as measured by the Recovery Attitudes Questionnaire (RAQ-7) (Borkin et al., 2000), a validated and co-produced instrument in assessing recovery attitudes, as well as participants understanding of Recovery. The seven-item RAQ-7 may be used to compare attitudes across different groups of individuals. It can differentiate those consumers who are familiar with recovery from those who are not. The measure can also serve an educational function as a focus of discussion for consumers, mental health professionals and the general public. Another

potential use of the RAQ is to assess attitude change over time. The original scale by Borkin et al (2000) consisted of 21 items that were inspired by Anthony's (1993) ideas about recovery. After administering the questionnaire to 825 individuals from a range of groups, a series of factor analyses were done and the number of items was reduced to seven. The instrument's internal consistency and its test-retest reliability meet conventionally accepted standards, making the RAQ a psychometrically sound instrument.

Section 3:   Assesses people's attitudes towards the key factors related to the development of Recovery College. Examples of statements/questions from each section are provided in Box 1.

Box 1: Example of Recovery College Questionnaire statements

Section 2: Recovery Attitudes Questionnaire (RAQ-7)
- *People in recovery sometimes have set backs*
- *Recovery can occur even if symptoms of mental illness are present*

Section 3: Training & Education
- *What role do you think training & Education has in the recovery process?*
- *If training & education was provided in a Recovery College what would you consider to be the three most important topics*
- *Where would you like recovery college courses to be delivered?*

Focus Groups, Interviews and Public Consultations

Researchers developed a script for the purpose of focus groups, interviews and public consultations (Appendix II). The questions sought participant views on their experience of;

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mental health services, personal recovery, recovery attitudes, recovery education, peer

support and how a recovery approach to education might be developed in the region.

Examples of statements/questions from scripts can be found in Box 2.

Box 2: Example of questions from Recovery College Interview/Focus Group scripts

Service Users/People with Self Experience
- *How would a recovery college help you/others?*
- *How would a recovery college relate to existing mental health services?*

Family/Carers/Friends
- *What are the particular needs of family/carers/friends that can be met by a recovery college*
- *What could your input be into a project like this?*

Staff Members
- *What is your experience of the concept of recovery to date?*
- *What are the particular needs of staff that can be met by a recovery college?*

4.4   Participants

Survey

Overview

There were 254 participants in the survey component of the research (218 online and 36

hardcopy). A total of 480 people navigated to the first page of the online survey

representing a completed response rate of 45%.

Gender

The 254 participants in the survey comprised of (24%) 60 males and 188 (74%) female. 6

(2%) people did not indicate their gender.

Age

Table 4.1 outlines the number of participants in each age category.

Table 4.1: Age of participants (N =254)

Age Range	Frequency	Percent %
18-25	15	6.0
26-35	63	25.0
36-50	122	48.0
51-65	52	20.0
66+	1	.5
Missing	1	.5
Total	**254**	**100.0**

Geographical Region

Limerick was disproportionally represented (n = 160). The next largest response region was Clare (n = 45), followed by Tipperary (n = 39), and, other regions (n = 10). This information is outlined in table 4.2

Table 4.2: Area of Mid West region (N=254)

Region	Frequency	Percent %
Limerick	160	63.0
Clare	45	18.0
Tipperary	39	15.0
Other	10	4.0
Total	**254**	**100.0**

Interviews & Focus Groups

Three focus groups (table 4.3) and eight one to one interviews (table 4.4) and were conducted across the Mid West.

Table 4.3: Focus group Information

Location	Stakeholder	N	Type	Information
Limerick	Staff	7	Focus Group	Mixed discipline, mixed gender, included mental health and non-mental health service staff
	Service Users	6	Focus Group	Mixed gender, mixed age group, 5 current service users
North Tipperary	Carers	7	Focus Group	Mixed gender, mixed age group

Table 4.4: Interview Information

Location	Stakeholder	N	Type	Information
Limerick	Staff	1	Interview	Male, experience of working in mental health and addiction services
	Carer	1	Interview	Mother of adult service user,
Clare	Staff	1	Interview	Female, 10+ years mental health service experience
	Service User	1	Interview	Male, middle aged, many years experience of mental health services
	Carer	1	Interview	Partner of service user
Tipperary	Staff	1	Interview	Female, newly appointed to mental health services
	Service User	1	Interview	Male, late 20s, new to mental health services
	Carer	1	Interview	Mother of adult service user, several years experience of mental health services

4.5   Procedure

The research was conducted by both experienced and novice researchers. Novices received research training on conducting focus groups and interviews. All members of the

commtittee were involved in qualiatative data collection. The study was conducted in a number of stages:

Stage 1   Online survey distributed through ARI contacts via email and online media

Stage 2   3 focus groups; one each with service users, staff members and family members/carers;

Stage 3   One to one interviews; 2 with service users, 3 with staff members and 3 with family members/carers;

Stage 4   7 community consultations were held with members of the public (with and without experience of mental health services);

Stage 5   Preliminary analysis of emergent results;

Stage 6   Output of report based on preliminary analysis.

4.6   Ethics

Ethics approval for the study was granted by the Health Service Executive (HSE) Research Ethics Committee in October 2013. All participants were given information sheets clearly delineating the research parameters and expectations. This also outlined the freedom to decline participation or to withdraw at any stage without prejudice. All participants signed informed consent forms (Appendix III). Careful attention was given to protect the anonymity of participants.

5.   Findings

Results from each section are presented below with reference to related open questions.

5.1   Overview

Overall findings indicate that people across the Mid West are supportive of the concept of recovery and have a good understanding of what it means. Qualitative findings showed that people felt there were weaknesses in the current mental health service and that a recovery education centre/recovery college would be a significant and positive step to remediating some of the challenges associated with current service provision. Participants were extremely positive towards recovery education that was inclusive and easily accessible and put forward a variety of suggestions to ensure the effectiveness of recovery education in the Mid West region.

5.2   Survey Findings

The survey component explored how participants understand the concept of recovery and how positive their attitudes were towards recovery (using the RAQ-7). Mean attitudes towards recovery were very high, which demonstrated that the majority of stakeholders hold a recovery-oriented outlook towards mental distress. Qualitative comments revealed a varied understanding of recovery.

Information on Scoring

RAQ-7 scores of "strongly agree" were allocated a value of 1, followed by 2 for "agree" responses, 3 for "unsure", 4 for "disagree", and, 5 for "strongly disagree" on a Likert scale of 7 questions. Hence, a total RAQ score of 7 indicates all responses were "strongly agree". A score of 14 indicates all responses were "agree". "Strongly agree" responses correspond with positive attitudes towards recovery while "strongly disagree" correspond with negative attitudes.

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Results

Participants who completed the RAQ-7 (N = 246) had a mean score of 12.63 (SD = 3.17, range 7 – 21), which falls between the "strongly agree" to "agree" range, and corresponds with positive to highly positive attitudes towards recovery. Mean scores for each participant group also fell within this range, indicating that positive to highly positive attitudes were common between groups (see Graph 5.1) for details on mean RAQ-7 scores per participant group). Findings also suggest that service users and staff members were more likely to strongly agree or be highly positive towards recovery relative to the other groups identified by independent samples tests.

Graph 5.1 Mean RAQ-7 scores
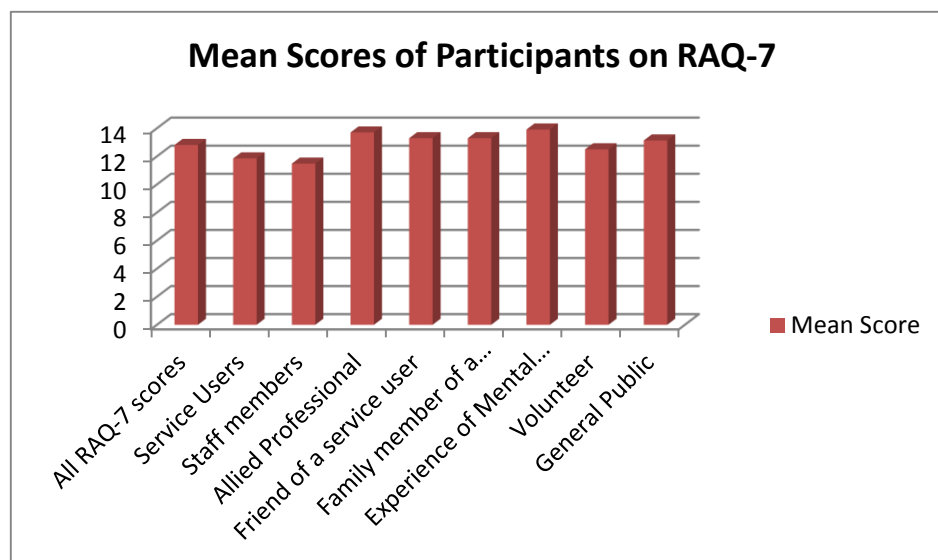
Factor Analysis

The RAQ-7 is divided into subscales:

Factor 1: Recovery is possible and needs faith.

- To recover requires faith.
- Recovery can occur even if symptoms of mental illness are present.
- Recovering from mental illness is possible no matter what you think may cause it.
- All people with serious mental illnesses can strive for recovery.

Factor 2: Recovery is difficult and differs among people.

▪   People in recovery sometimes have set backs.

▪   Stigma associated with mental illness can slow down the recovery process.

▪   People differ in the way they recover from a mental illness.

Findings suggest that respondents felt strongly that recovery is difficult and differs amongst people (M=2.04, SD=.62). They were less sure that recovery is possible and requires faith (M=1.49, SD=.44) (Table 5.1). On analysis, responses indicate that while participants were very sure that recovery was possible, there was some diversity of thought on whether it required 'faith'.

Table 5.1 *Mean RAQ-7 Scores for Factor 1 and 2 by Item*

Item	*M*	*SD*
Factor 1	2.04	.62
Factor 2	1.49	.44

Note: Lower scores indicate more positive attitudes towards recovery

Section 3

A content analysis was used to analyse the open-ended responses, which allowed determination of higher frequency codes within responses.

(i) What Is Recovery?

The five concepts emerging from this question were;
'independent ability', 'accessing other supports', 'return to normal', 'process of change', and, 'not defined'. There were 140 valid responses. An explanation of each theme as well as examples are presented below.

Recovery as regaining independent ability

45% (n = 63) associated recovery with this concept. It relates to views of recovery as an independent ability, or development of a set of personal mechanisms such as; coping/self-care, functioning, accessing inner resources, autonomy in decision making, and contributing to daily life (Box 5.1)

Box 5.1 Related quotes

- *'When recovery takes place people are able to partake in the things associated with everyday living'*

- *'Recovery is about getting up each day and no matter how much I feel like X the day I just get on with it'*

- *'When the client is functioning to the best of their ability and is content about their level of functioning'*

- *'In essence recovery at its simplest would seem to imply that people live each day to the best of their ability with acceptable levels of functioning, normative in society.'*

Recovery as being able to access other supports

29.29% (n = 34) of respondents associated recovery with this concept. It relates to a view of recovery that involves accessing supports and being able to function with services, family members, friends and society in general (Box 5.2)

5.2 Related quotes

- *'Engage in family, social and employment to an extent that supports their self esteem and meaningful participation in society'*

- *'Recovery is a combination of the following: a) Family support b) a desire to recover, c) ongoing support from services'*

- *'Support from friends and family and your local services.'*

- *'having good relationship with family and friends'*

Recovery as a return to normal

17.86% (n = 25) indicated that recovery was a return to normal. This view was associated with a view of mental illness as similar to a medical condition that one 'gets better' from (Box 5.3)

Box 5.3 Related quotes

- *'Supports and routines to get you well again a.s.a.p.'*

- *'Being able to get back to the person you were in the past'*

- *'Getting back to the way you felt before'*

- *'Recovery is where you get better from a short or long term illness'*

Recovery as a process of change

In contrast to the 'return to normal' concept, the 'process of change' concept associated recovery with a journey/process towards becoming a "new person" and taking on significant personal learning. This is associated with a newfound lifestyle/world view. This was indicated by 15.71% of respondents (n = 22) (Box5.4).

Box 5.4 Related quotes

- *'A realisation that life cannot be as it was before. Illness changes people…Recovery is ongoing'*

- *'A learning curve from which you have grown, and that you have shifted from that place'*

- *'It's a journey but not an endpoint'*

- *'Engagement in a process of development towards adaptive ways of thinking'*

Recovery as undefined

While small in number, some respondents disagreed with the concept of recovery and therefore could not define it. This was indicated by 2.86% of respondents (n = 4) (Box 5.5)

Box 5.5 Related quotes

- *'Recovery for some people can not always happen due to the illness'*

- *'I do not believe in the word recovery… For me to believe in recovery is to believe that there was an illness in the first place. Labels are put on people by those who don't understand the inner workings and sensitivities of others'*

(ii) What role do you think training and education has in the recovery process?

The five most frequent content codes that emerged from this question were; 'vital importance', 'stigma reduction', 'service-user education', 'staff education', and, 'practical skills'. There were 140 valid responses. An explanation of each content code and examples of each are presented below.

Vital importance

45% (n = 63) of responses related to the vital importance of training and education. Responses strongly indicated that training and education was a necessity and of vital importance to recovery (Box 5.6)

Box 5.6 Related quotes

- *'Training and education are vital in helping people to identify their own resources and learn about themselves'*

- *'I believe information is power. If you have all the information of what is affecting you, how and your reaction to it then that information, coupled with the information of how to support yourself to live an independent fulfilled life again, will lead to recovery. Education and training is important for those reasons'*

- *'It's the most important part of recovery process in order for it to be successful'*

- *'Knowledge is a vital key to recovery without knowing the problem one can not begin to fix it.'*

Stigma reduction

This was indicated by 17.14% (n = 24) respondents.   It related to a view of training and education as a means of reducing stigma and aiding recovery (Box 5.7).

Box 5.7 Related quotes

- *'Break down the stigma of poor mental health and encourage people to talk about it the way they would any other illness, so that it becomes ok to say I have depression or I have bipolar disorder in the same way it is ok to say I have cancer and to expect support, rather than isolation.'*

- *'I think its very important to clear up the myths attached to mental illness and that anybody can suffer from it at any stage in life it affects all ages and genders'*

- *'Awareness of mental health issues. De stigmatises mental health in the family'*

- *'Maybe the barriers are between the general public and 'them' and us?'*

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Service user education

This was indicated by 47.86% (n = 67) of respondents. It relates to views (implicit and explicit), that recovery training and education was limited for service users in service delivery (Box 5.8)

Box 5.8 Related quotes

- *'It gives people the skills and knowledge to manage their own mental health and take responsibility for it rather than being dependent on the instruction of mental health professionals.'*

- *'It enhances peoples skills to find their own answers to their own difficulties'*

- *'Training and education would help the individual to meet their challenging needs'*

- *'It is important that people suffering from mental health problems are the main drivers of their own recovery and take responsibility for it.'*

Staff Education

'Staff education' was constituted by a view that recovery college education could include CPD (continuing professional development)and information/education on mental health for both statutory and non statutory mental health providers. This was indicated by 17.86% (n = 25) of respondents (Box 5.9)

Box 5.9 Related quotes

- *'Training is important for both the person who is recovering and the personnel that she meets in statutory and voluntary mental health services.'*

- *'Personally having a good person or persons to support the person that needs the care, also understanding. The person that is going to provide this service would have to have a great understanding with regards to mental health.'*

- *'On going education for service providers is essential. Best practice that is research based and current should is necessary.'*

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Practical skills

17.86% (n = 25) indicated that training and education had a key role in developing practical skills for those with mental ill-health. This includes daily living skills as well as leisure and employment related activities (Box 5.10)

Box 5.10 Related quotes

- *'Practical exercises in re-entering the workforce (buddy mentoring or appropriate internships) or social groups (sports clubs etc).'*

- *'Improve access to mainstream services (e.g. hobby groups/courses etc)'*

- *'Daily chores at home like a little cooking and cleaning and washing themselves and changing their clothes in their flats'*

- *'help getting back to work.'*

(iii) If training and education was provided in a recovery college, what would you consider to be the three most important topics?

The seven most frequent codes that emerged from this question were: 'coping' (24%, n = 92); 'service related' (19%, n = 92); 'practical' 23.20% (n = 90); 'understanding knowledge, education' (17% , n=66); 'specific to mental health' (11%, n = 42); connectedness' 4.90% (n= 19); and 'recovery' (1%, n = 5). These answers were typically 1-2 words. There were 420 valid responses (i.e. 3 each per 140 respondents). Taken together the codes account for 92.38% of all 420 responses from 140 participants. Content explanations and accompanying quotes are outlined in the box below (Box 5.11)

Box 5.11 Codes and quotes in relation to Training & Education

Codes	N	%	Examples
Coping The theme was constituted by a view that the most important consideration for training and education is to promote coping, self-esteem and life management skills for service users.	92	24%	'Self esteem/ retraining', 'Self worth', 'Self Responsibility', 'coping skills'

Service The theme relates to the kinds of staff, service ethos, and, environment that training and education should facilitate within the college.	92	24%	'Friendly environment', 'shared goals', 'Therapeutic engagement', 'experienced professionals', 'Elimination of Medication'
Practical skills Indicated the most important consideration for training and education in a recovery college should be practical skills.	90	23%	'Participation in sports etc', 'strategies in time management', 'Creative Arts and physical act', 'helping people with employment', 'reading and writing'
Understanding/Knowledge/Education This theme was constituted by a view that the most important role of education was to provide generic	66	17%	'Mental health awareness', 'Life skills and self awareness', 'understanding', 'Knowledge of the action to talk', 'Understanding of their illness', 'How can we normalize the subject'.
Specific to Mental Health Indicated training and education should be specific to mental ill health or serviced by/delivered to mental health professionals- particularly psychologists and counsellors as opposed to medication.	42	11%	'Psychological supports.', 'Psychology', 'depression', 'Cognitive Behaviour Therapy', 'The professional counselling', 'Accessing non medical services'
Connectedness Indicated promoting social connectedness or interpersonal relations with peers and society, was the most important consideration for training and education	19	5%	'Mental health and society', 'inter personal relationships', 'meeting others', 'peer support', 'interpersonal skills'
Recovery Explicitly mentioned recovery should be a primary consideration of training and education in a recovery college	5	1%	'Recovery skills', 'tools for maintaining recovery'

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* Note % respondents do not equate to 100% due to multiple answers

(iv) Where would you like recovery college courses to be delivered?

In total there were 139 valid responses to this question. The majority of respondents (N=69) indicated that recovery college courses should be available across all three areas of the Mid West. 1% (n = 1) indicated Clare, 9% (n = 12) indicated Tipperary, 49% (n = 69) indicated all 3 locations, and 9% (n = 12) indicated the 'other' category, which was constituted by all Ireland and any combination of the three specified locations (Box 5.12)

Box 5.12 Areas respondents would like Recovery College courses delivered

Area	N	%
All Areas	69	49
Limerick	45	32
Tipperary	12	9
Clare	1	1
Other	12	9
Total	**139**	**100%**

(v) What do you think would be most important to consider in developing a recovery college?

Five frequency codes emerged from this question; 'accessibility', 'funding', personnel', 'curriculum', and 'environment'. These answers were typically 1-2 words. Hence, examples are presented in theme explanations rather than related quotes. There were 420 valid responses (i.e. 3 each per 140 respondents). Taken together the codes account for 74.52% of all 420 responses from 140 participants (Box 5.13)

Box 5.13 Codes and quotes in relation to the Development of a Recovery College

Codes	N	%	Examples
Accessibility This theme was constituted by the view that recovery education should be accessible to as wide a range of people as possible	92	29%	'Accessibility', 'Location', 'Make it accessible', 'central', 'Public accessibility'
Funding Relates to concerns that resources should be well funded and used effectively	22	7%	'Funding', 'on going funding', 'funded', 'Not wasting resources'
Personnel This theme was constituted by the view that professionals should be a key component of service delivery and that these professionals should espouse a bio psychosocial perspective on mental health	88	28%	'Client led', 'Not medical more Life coaching', 'Collaboration', 'Strong service user input', 'professional support', 'multi disciplinary involvement
Curriculum Respondents indicated curriculum was important to consider when developing a recovery college. This theme includes references to both the importance of curriculum and specific suggestions about the curriculum	65	21%	'Practical techniques', 'A top class curriculum', 'reading', 'writing', 'varied courses', 'including creative activities', 'coping with loneliness', 'well researched
Environment Relates to how the recovery college should make persons feel while they are attending, including safety/respect considerations	46	15%	'Private', 'Comfortable Environment', 'friendly helpful environment', 'Respect for all', 'Peaceful', 'listening', 'Gentle', 'Trust'

(v) Suggestions

Many of the suggestions wished the researchers "good luck" (N=101, 72%), which may indicate a positive attitude towards the development of a recovery college in the region. However, two content codes were also evident. These were 'inclusion' and 'specific suggestions' (Box 5.14)

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Box 5.14 Codes and quotes in relation to Suggestions for a Recovery College

Codes	N	%	Examples
Inclusion Respondents reiterated the need for the recovery college to be inclusive to all.	24	17%	'Bringing this to general settings and reaching out to as many as possible.' 'Talk to community leaders and include all services linked to mental health including hospitals' 'Make the atmosphere as normal as possible and break down barriers between staff and clients'
Specific Suggestions Specific suggestions focused on ideas for effective delivery for a recovery college. Respondents provided ideas in the areas of a curriculum, learning supports and aids, the college environment, the qualifications and professionalism of staff as well as increasing the accessibility of the service.	15	11%	'Don't label it as a hospital or medical centre.' 'Have services available outside of normal hours for support and to facilitate people who are working' 'Provide buddy system to avoid lack of transport obstructing peoples participation, which is key in rurally isolated areas' 'Book rental scheme' 'A cafeteria run by college where all profit goes back into college and allows students to have work experience in cafeteria.' 'Jungian-based body soul work and journaling, integrating artistic expression and self-esteem.' 'Learning assistants for students with difficulties.' 'A mobile unit to go to all locations with information/lectures' 'Have qualified staff/service users with life experiences'

5.3   Focus group/Interview Findings

The following section outlines the findings from the three focus groups and eight in depth interviews that were conducted during the research. Given constraints of budget and time data was not transcribed and analysed. Rather the below reflects researchers detailed notes on audio files, a technique known as pawing or eyeballing. Methods of analysis included (i) repetition, whereby researchers looked for topics that 'occurred and reoccurred' (Bogdan & Talor, 1975, p.83) and (ii) similarities and differences, whereby researchers searched for similarities and differences between groups (Bogdan & Biklen, 1982, p.153).

Attitudes and Opinions of Participants

(i)   Description of recovery?

Participants described recovery in a variety of ways. Some felt it was ***developing independence*** and learning how to deal with and ***overcome the challenges*** encountered in life. Others described it as having the ***knowledge*** of all the options available to them and ***empowering them*** to make their own decisions. For others it meant ***having a focus***. For example, taking up new activities and developing new interests gives people meaning and enables them to integrate themselves more in society. The concept of ***returning to society*** was also important, with participants noting that recovery is about inclusion, not exclusion.

Some people described recovery as a ***personal*** and an ***ongoing process*** and not an end goal. However, there was some confusion as to the level of recovery that can be achieved. One participant stated that people with more severe symptoms sometimes seem to have better recovery outcomes than those with less severe symptoms. Another participant found the language around recovery ***very aspirational*** , which they considered "grating".

Service users and carers identified that staff needed to provide ***guidance and support*** to facilitate recovery. It was also stated that recovery needs to be an integral part of the service as opposed to being assigned to a particular activity or person. A sample of quotes relating to each of these concepts is presented in Box 5.15.

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Box 5.15 Related quotes

- *'It's a way for people to learn how to cope with their life.'*

- *'No going back, a forward road'*

- *'And I suppose recovery is about giving them the power to make a choice about their own treatment and what is that they actually want or don't want from it.'*

- *'The two don't always go hand in hand really' [level of symptoms and level of recovery]*

- *'Can be more Dr. Phil than Dr. X'*

(ii)   Mental health services and service user's needs

Participants acknowledged that many areas of the mental health service work well and that there is a lot of recent positive change. However, it was highlighted that the system had significant challenges across a number of areas. A sample of quotes relating to each of these challenges is presented in Box 5.16

Lack of Resources

Participants reported a lack of recovery related resources in many areas of the service. It was highlighted that people who are in need of help often have to ***travel long distances*** to gain access to services. It was also noted that when people did access services, their experience was of ***long waiting lists*** and an ***overcrowded service***. Participants identified what they perceived as an ***over reliance on medication.*** The environment is also highlighted as a factor, with ***poor facilities*** which are not conducive to mental health. Examples were given of certain day hospitals. The issue of ***limited access to courses*** and ***very little for young people*** was also raised.

Lack of Communication

Some participants reported that communication within the system often seems weak. It was thought that some parts of the service appear not to be aware of the actions of others. Services user participants identified having ***little input into their treatment*** and that they are often ***not consulted*** before decisions are made. This is particularly evident in the area of

medication prescription. Participants also noted that *service providers can also seem quite unapproachable* and it is difficult for service users to give feedback about their service experiences. In addition, when feedback is given, it is perceived as being ignored, e.g. feedback re time use at clinics has not resulted in desired changes. Participants reported a noticeable *lack of communication between service providers and family members/carers*. This was noted as being quite a stressful experience, leaving carers feeling excluded and undermined. On occasion, family members/carers have felt that their *input is unwelcome.* A need to educate family about mental health and medication was highlighted.

Lack of Cohesion in Service Delivery

Participants noted a *lack of cohesion* in service delivery, as well as a *lack of leadership* in relation to recovery. One staff participant stated that there isn't yet a sense that a recovery approach is "bedded down" in the region in a uniform way. Here, it was thought that for recovery to succeed, the services need to standardise service delivery.

There is also a perceived confusion among staff regarding recovery oriented training. Younger staff members were considered to have received more recovery focussed training, but that older members of staff had largely received medically oriented training. This may indicate that staff members are working with different approaches. Participants suggested that retraining of staff be a priority to increase the recovery orientation of the service. It was acknowledged that much time is required for change to become evident.

Box 5.16 Related quotes

Lack of Resources
- *'The most painful part is that it takes so long – in the meantime people are suffering'*

- *'Sometimes it's crazy, there are people waiting two hours to be seen. Em, so I mean realistically I'd say let's have a whole day clinic twice a week and give people longer appointments or whatever.'*

- *'And I used hate going in myself because when I'd go in, it was only a small, tiny room and there could be twenty people sitting down. Not only twenty people sitting down, but along the corridor there could be another five or six standing waiting for the services, for whoever they were going to meet. It was crazy'.*

- *'But myself it kind of made me more anxious because I, I'm seeing people going into the centres like that. Even the fact they're sitting in a waiting room, a small little waiting, waiting room. I mean where's the wellbeing? Where's- It can be improving people's wellbeing stuck in a small little room.'*

- *'There's absolutely nothing out there for young people'.*

Lack of Communication
- *'A lot going off, going on and I didn't know about it. And then I didn't know about the support services. Nobody said anything about support services. So I was just doing my, you know going through my life and getting on with I had to do. I didn't think I needed help, but I should have had help as well because I mean it was causing problems at home.'*

- *'It's hard when you're driving 42 miles to see your daughter and then being told she was discharged back to her college address.'*

- *'But I didn't know that there was help there, that there was peer support there.'*

- *'Em, well I suppose, for the majority of people who use the service, I'd imagine they come in, they see the doctor, they ah get a prescription and they're asked to come back in three months.'*

- *'It tends to be medication first and then these are the other bits that you can do or not do.'*

- *'They don't take family into account in the medical side of things. It's really their way or no way really.'*

Lack of Cohesion in Service Delivery
- *'There's lots of committees doing lots of different things. Nobody really knows what's going on. So there's kind of, it's difficult to see where the co-ordination or where the leadership really is.'*

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(iii)   Needs of the community/individuals/stakeholders in relation to recovery?

A variety of concepts emerged from the question of the needs of the community/individuals/stakeholders in relation to recovery. A sample of quotes related to each concept is presented in Box 5.17.

Education

The importance of being informed, as an aid to an individual's recovery, was identified. The role of active education was seen as necessary to facilitate recovery. The transition from a passive caring role could also be facilitated by recovery education. Education regarding mental health difficulties and associated treatment approaches is considered essential to a full understanding of illness and recovery. Similarly, staff education was noted as necessary in order to promote greater understanding and the facilitation of recovery.

Support

Participants described the benefits of having support, a place to meet others and not being isolated. This is of particular importance when experiencing distress.   Encouragement is also needed to increase confidence, boost self esteem and promote recovery. Access to mental health professionals for counselling/support was seen as important. Peer support was also considered an important component of recovery.

Inclusion of Family

According to participants, the needs of families and carers should be clearly identified and form an important component of care. The education of family members/carers was considered to be vital in gaining a greater understanding of individual experience and identifying the most appropriate ways to help their loved ones.

Box 5.17 Related quotes

Education
- *'The psycho-education, the insight.'*
- *'Moving from you know caring for an individual to educating them and supporting them.'*
- *'Well it [education] would certainly open their [staff] minds quite a lot.'*

Support
- *'No need to suffer in silence.'*
- *'Time out, recovery and laughter.'*

Inclusion of Family
- *'So it's us that have to live with the experience of the mental health illness or the mental health difficulty.'*

(iv)   Attitudes in relation to a Recovery College

There were a range of attitudes expressed in relation to a recovery college. A summary of quotes relating to these are presented in Box 5.18

Role of Education in Recovery

Learning how to identify signs of mental ill-health and knowing how to respond is considered a key stakeholder need. It was highlighted that while education plays an important role, it should not be viewed in isolation. Engagement in activities was also cited by all stakeholders as very important to recovery. This was linked to the significant benefits of being active. The education of families/carers was also highlighted as an important factor for consideration, enabling them to better support and assist a loved one's recovery.

The idea of a recovery college was unanimously regarded as highly beneficial to all stakeholders. Staff identified its potential as a useful resource which would compliment existing services.   In addition all stakeholders viewed the recovery college as a driver for change to services that would change the perception of the mental health service.

Types of courses

Participants identified a preference for a broad range of recovery focused courses. It was considered that an academic emphasis could be off putting for some and that the

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curriculum should encompass a diversity of learning styles. Physical health, fitness and life skills were suggested as important course content.

<u>Some suggestions:</u>
- Anxiety Management
- Art Therapy
- Yoga Fitness
- Talking groups
- Coping skills
- Parenting
- Cooking
- Gardening
- Computers – basic and upwards
- Illness and medication
- Music
- Activities for fun

Location/Description

All participants favoured an easily accessible location. It was stated that it should not be located in a building associated with mental health services e.g. day hospital. Facilities such as library and café were identified as desirable features.   This was particularly important in the context of socialising and meeting new people. It was noted that the recovery college should be visible in the community, to help reduce the stigma associated with mental health. Some participants stated that locating the college in a pre-existing third level institution could also reduce stigma. This would also ascribe a certain level of status and align courses/qualifications to mainstream education.

Who is it for?

Stakeholders overwhelmingly agreed that a recovery college should be open to anyone who wishes to attend; service users, staff of the mental health services, family members, carers and members of the public. Opening the college up to all of the community breaks down the stigma typically associated with attending a mental health service.

Who should deliver programmes?

Participants stated that courses should be designed and delivered by mental health professionals, carers and service users. It was noted that people attending the college may respond better to their peers than they would to professionals. However, the unique contribution of all stakeholders was acknowledged.

Involvement in the design and delivery of programmes was considered to offer service users more responsibility, thereby promoting a sense of ownership of the college. However, the potential for excess pressure/stress on service users involved was highlighted. Any service user involved in delivering programmes in the college needs to receive appropriate training and support.

Other

Getting Service Providers on Board

Participants noted the importance of including service providers in the development of a recovery college in order to promote inclusion and minimise any perceived threat to, or judgement of current service provision.

In particular, the importance of getting doctors on board was emphasised.   It was acknowledged that they have a central role in encouraging people to utilise the recovery college, thereby moving away from the traditional medical model of service delivery.

Ensuring it is Accessible for Everyone

Stakeholders emphasised the importance of including people of all levels of ability. In order for this to be achieved, different experiences of mental illness/levels of ability should be considered in configuring a recovery college. Suggested measures to address these concerns included running classes at night time; smaller numbers of students; individual learning tutors; mixed methods of teaching.

Box 5.18 Related quotes

Role of Education in Recovery
- *'I mean those, just even to know about the medicines, the background or how I promote am his wellbeing, you know.'*
- *'It's really important we mind our own mental health, we could use recovery college to do that.'*

Location/Description
- *'Maybe somewhat of a community.'*
- *'Because we do too much hiding stuff anyway at the moment.'*

Who is it for?
- *'A college for the people run by the people.'*

Who should deliver the service?
- *'Not good for people attending the services to have all the responsibility.'*
- *'Should be 50:50.'*
- *'There's such a wealth of experience available between patients, carers and health professionals – a mountain of experience.'*

Other
- *'They [staff] need to understand it and not see it as a threat to their work or not see it as a threat to what they do or some sort of a judgement of what they've done in the past.'*
- *'It could be an option to go at night time. It would be an option for people, you know day or night, you know they have somewhere to go and meet up with other people.'*

5.4   Community Consultation Findings

7 community consultations were held in locations across the Mid – West.   These were facilitated by members of the recovery college committee. They were conducted in locations associated with mental health (e.g. Aras Follain, Nenagh) and those not (e.g. Our Lady of Lourdes Family Resource Centre, Limerick). Every effort was made to include the views of participants from rural and urban areas. The format of the sessions was informal – the sessions were facilitated by one person whilst another person made detailed notes on thoughts and ideas emerging from the group. Researchers reviewed the notes made on each session and the information outlined here is a collation of the data gathered.

Attitudes and Opinions of Participants

(i)   How did they describe Recovery?

Participants had varying understanding of recovery which ranged from taking responsibility for oneself, to being about rebuilding oneself 'brick by brick'. People also felt that it should incorporate all aspects of the self, including physical, emotional, intellectual and spiritual. It was noted that recovery allowed people to have joy in their lives despite whatever mental distress they may be experiencing.

(ii)   How do they describe the mental health services and service user's needs?

People had very strong opinions on the existing services. They noted that some aspects were working well such as the GP service (i.e. referring people to mental health supports) and the quality of some individual therapists/doctors. However, in general, people felt that the current service requires much improvement. People frequently identified that the service they experienced was too clinical and not responsive to individual needs. They noted that often the service is very medical in its outlook and that there was no continuity of care in the service, as you could 'meet a different doctor every time'. Some had such poor experiences that they stated they will never return to use the service.

(iii)   What are the needs of the community/individuals/stakeholders in relation to recovery?

Participants identified a wide range of needs in relation to recovery. They felt that people need to learn about what is happening to them when they have mental health difficulties and learn positive coping mechanisms. They said that recovery should focus on daily living skills so that people can learn how to live "a life of good health". They noted that a Recovery College could have an important role to play in this and could include courses on: life skills, assertiveness training, personal development, WRAP, anger management, anxiety management and the role of medication.

(iv)   What are attitudes in relation to a Recovery College

Role of Recovery Education

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There was an overwhelmingly positive response to the development of a recovery college. Participants connected with the concept, and saw this as an opportunity for those involved in mental health services to learn about different pathways to recovery. Great energy and enthusiasm in relation to the Recovery College was evident.   This was tempered, however, by a sense of people having been 'let down' by services in the past.

Type of Courses

There was diverse opinion on what should be provided at a Recovery College from creative and artistic therapies (art, music, yoga, dance etc.) to mental health specific programmes (suicide awareness, anxiety management, education on medication, managing depression etc..).

Location/Description

Whilst people recognised that the Recovery College should be accessible to all, they also acknowledged the need to 'start somewhere'. However, many said that transport is a huge issue and that any initial programmes should include an element of outreach. Ideas included 'mobile recovery' or 'recovery in a suitcase' to cater for the needs of people to access resources in hard to reach places such as County Limerick/North Tipperary or rural parts of Clare.

People strongly emphasised that the Recovery College/Education Centre should be warm, secure, supportive and empowering - aspects which they noted are not currently present in the formal mental health services. People also stressed that accessing the college should be free and well-resourced with learning materials such as audio books, internet access and a library. People would like different types of spaces to be provided in the college such as classrooms, relaxation rooms, exercise areas and a café.

Who is it for?

People were very clear that the Recovery College needed to be inclusive and cater for diversity including marginalised groups such as the travelling community or migrant communities. They noted that when it comes to recovery education 'no-one should be turned away'.

Who should deliver the programmes?

People emphasised the importance of self-experience in the development and implementation of the Recovery College/Education Centre. They felt that those who had 'been through it themselves' had a lot to offer participants in the college. However, it was noted that these people should be trained to facilitate and run classes. In addition, the need for professional involvement in the service was equally highlighted. It was felt that expertise in a wide range of areas should be available, with an equal division between professionals and user/past users of the service.

What other aspects should be considered in developing a Recovery College?

There were many aspects of importance highlighted by the public in consultations. For example, people felt that getting the right name was hugely important. Some felt that it should reflect what it is i.e. a recovery college, as it inspires confidence in one's progress e.g. 'helps me to think I am moving on, getting a qualification'. Others thought that using words such as 'college' might be off putting for some e.g. 'Recovery College isn't a good name – makes it sound like there is something wrong with you'. Several names were put forward for consideration such as: 'Forward Journey College', College of Well-being' 'Maintaining Health Academy' and 'College of Life'. Other aspects highlighted were; the need for the college to be well marketed with good brochures and advertising; open days; diversity of education formats to be delivered e.g. discussion forums, active learning etc.

Word Cloud highlighting some of the key aspects of developing a Recovery Education Centre as identified by participants during public consultations. Bigger words indicate that more people identified the theme as important.

6.   Discussion

6.1   Overview

Overall, findings of this research indicate that there is strong support for the concept of recovery across the Mid West region. In particular, participants in the research emphasised that recovery education was a vital component of orienting services towards a recovery ethos and were broadly supportive of developing such a service.

6.2   Current Challenges

Although Irish mental health services have evolved over the last number of decades to a more person centred orientation, findings from this research indicates that there is still significant scope for improvement. In general it was felt that there was an over emphasis on medication and that other psychological/therapeutic supports were often viewed as add-ons or not offered at all. This reflects an adherence to a medical model approach to service delivery, an approach which the HSE is actively engaged in reorienting (DoHC, 2006). In addition, the lack of available resources in local communities was highlighted by participants in the study. This is supported by a profile of the Mid West region which indicates that many rural areas have poor transport links and lack specific mental health resources.

6.3   Understanding Recovery in the Mid West

In general people across the region had a good attitude towards recovery and a strong understanding of its meaning. People identified it as a 'process' and as a 'return to health' or as the 'ability to function' in everyday life with and without the symptoms of mental illness. People noted that support from services, as well as from family and friends was an important ingredient in a persons' recovery, but that people should be empowered to make informed decisions in managing their own health and well being. Many of the descriptions of recovery mirror previous understandings of recovery outlined by Bonny and Stockley (2008) as well as Deegan (1998). A definition of recovery for the region has been developed that encompasses the views and perspectives of this particular community.

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> **Mid West Region Definition of Recovery**
>
> *'Recovery is an ongoing process and is not an end goal. It describes a person's journey towards independence, and embodies a belief that one has purpose and value with or without the symptoms of mental illhealth. It is made possible by the support and guidance of others but ultimately it is about making educated choices as an individual about how best to manage one's own well being and health'.*

6.4   Recovery Education Development in the Mid West

In general, people highlighted the importance of education in the recovery process and indicated that there were serious gaps in education provision across the region for all stakeholders. Participants signalled an appetite for change and there was a very strong sense that change could be achieved though the development and implementation of a recovery college/education centre, both at an individual level and organisational level. This aligns well with existing literature, which indicates that recovery education centres can be catalysts for both personal and systems change. Whilst evidence for the effectiveness of recovery education centres has yet to be established, the momentum behind such an initiative (as indicated by the findings) positions the Mid West as a leader in recovery education with the opportunity to add to the evidence base as to its effectiveness.

Co- Production and Co-Delivery

Although researchers identified that there is currently a wide range of mental health and personal development programmes available across the Mid West region, the majority of these are not founded on recovery principles. Co production and co delivery of recovery education is central to the values and ethics of a recovery ethos. To date service users/family members/carers in the Mid West stated that they have had little to no input into the design or delivery of existing programmes. Participants in this study were emphatic about the need to include both staff and service users (and other key stakeholders) in the design and delivery of recovery focused education. They placed huge value on the 'expert by experience' and felt that although service users shouldn't have the main responsibility, a

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partnership approach was necessary for the success of the intiative. This is an important aspect of the recovery movement and aligns with prior research, which states that services 'need to start listening to people about what works for them just as we would if they had diabetes and were managing their own condition' (Davidson, 2005). Programmes such as 'The Expert Patient Programme' in the UK embody the professional/service user led programme design, and it is noted that people with experience of using mental health services can be powerful catalysts for change (Davidson, 2005). In this paradigm the role of professionals is seen as that of a companion or fellow traveller rather than as an expert, which is a difficult transition for many involved with the mental health services. Findings from this research indicate that participants felt that a recovery education centre in the Mid West would be a positive step towards achieving this change.

Accessibility

It has been noted that the Mid West region has a number of urban centres but is largely rural with varying degrees of access to transport and services. This is in contrast to existing education centres in Nottingham and South London that cater for a largely urban community. Participants in this study felt strongly that the needs of people in hard to access areas should be considered in the development of any recovery education initiative. Whilst people acknowledged that urban centres were best placed to serve the needs of the majority they favoured a hub and spoke type model so that those in rural areas were not disadvantaged.

It was also emphasised that any proposed centre needs to be tangible and visible to the community. Stakeholders emphasised the need to be inclusive of all groups within the services and also within the broader community reflecting a population approach to the centre. It was important to people that the college should have a physical location in the community so that people would know where to go and have an access point. Participants wanted this to be in a neutral space that was not previously associated with the mental health services e.g. a day hospital. Participants stated that existing centres of education such as a university would be good potential locations. They also noted that having a hub provides a social space to meet up with others and share experiences which was viewed as an important aspect of the approach. This ties in with themes of social reintegration and assuming power and responsibility as indentfied by Bonny and Stickley (2008).

Service Delivery

Many ideas and suggestions for service delivery emerged from this research project. Participants highlighted the positive change recovery education could have on overall service delivery. Participants identified a significant gap in the skill base of staff within the mental health services. In particular, they noted a disparity between newly trained staff members and long standing staff members in their knowledge of recovery and ability to provide a recovery oriented service.

In addition, participants felt that the voice of service users and family members/carers was absent in current mental health services. They noted that much work needed to be done to build the capacity of service users/family members/carers to be more involved at both governance and individual levels. The recovery education centre/recovery college was put forward as a key element to affect change in this area. People felt that engaging all stakeholders in recovery education had the potential to: expand the knowledge and skill base of staff members; prepare staff members to engage with service users in a recovery focused way; to empower service users/family members/carers to engage with services; and to build service user autonomy in managing their own health and wellbeing. This aligns well with the goals of A Vision for Change (DoHC 2006) and the strategic goals of the Mid West Mental Health Services (2014).

Participants were also concerned with how the recovery education service would be delivered. They noted that out of hours opening should be considered so that everyone had the opportunity to access the programmes provided. They also emphasised that the service should be well resourced, which related to two aspects. The first was the need for a secure funding structure. Participants stated that the HSE should invest in the service and take a lead role in its development and implementation. The second related to the types of resources available within the service. Participants wanted resources such as books, a library space, a café etc. They also wanted the service to be well staffed and to include professionals, peer trainers and peer tutors so that everyone could benefit from the programmes.

In relation to curriculum development participants had a wide range of ideas on what should be delivered by the recovery education centre/recovery college. These fell broadly into three categories. (i) Participants wanted personal development type courses that focused on aspects such as self esteem, confidence, assertiveness training etc. (ii) participants wanted practical life skills courses such as time management, organisation skills, fitness programmes and cookery and (iii) participants wanted mental health specific programmes such as navigating the mental health services, anxiety and depression management, coping with disorders, managing medication, understanding recovery etc. The expectations of a recovery education centre based on these three strands is outlined in Figure 6.1

Fig 6.1 Figure outlining the three areas of curriculum focus for a recovery college as outlined by participants

6.4   Recommendations

Based on the findings of the research project the recovery education subgroup recommend the following in order to realise the vision set forth by the participants of this study:

- The establishment of a clear governance structure to implement and manage the roll out of an education approach to recovery.

- A steering body to be appointed which includes representation from key community partners e.g. VEC, UL, LIT, NLN etc.

- The development of a strategic plan for the roll out of a recovery education service across the region.

- A clear pathway of communication to be established with the National ARI team and links made with other areas of the country establishing similar models or approaches.

- Recovery education initiatives to commence on a phased pilot basis with a clear evaluation system built in.

- Co-produced recovery focused modules/workshops to be developed for all stakeholders.

- The encouragement and support of staff members in the mental health services to participate in recovery focused education. HSE mental health services management team to develop a strategy to release staff to attend, co-produce or co-deliver training/modules.

- The support of innovative strategies that enable service users to participate and benefit from recovery focused education

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- The enhancement of links with partner organisations to ensure a collaborative and sustainable approach to the development of recovery education in the Mid West

- Continuous monitoring of module relevance and module content with special attention to recovery values

6.5   Limitations of the Study

There are a small number of limitations to note in the interpretation of the results of this study. The principal constraint was the response rate to the survey. Whilst 480 people navigated to the first page of the online survey just 218 completed it (does not included those who completed through hardcopy) representing a response rate of 45%. It is likely that an element of non-response bias is present that may have skewed the results. However given that response rates of 30% are common when using online surveys the response rate in this study could be viewed positively. In addition the qualitative research adds weight to the findings of the survey data thus increasing the likelihood that the findings are indeed representative of the overall target group. A secondary limitation of the study was the time and financial constraints of the study. This research was completed on a voluntary basis which affected the timeline of the project and the ability to access as wide a range of opinion as possible. However despite the limitations this study elicited valuable information as to the components affecting the development and implementation of a recovery education centre/recovery college in the Mid West region.

6.6   Conclusions

The aim of this research study was to access the attitudes and opinions of key stakeholders in the Mid West mental health service in relation to recovery and recovery education. Overall participants demonstrated positive support for the concept of recovery and comments provided by participants led to the development of a definition of recovery unique to the people of the Mid West area. In addition participants viewed the development of recovery education as an important aspect of promoting a recovery ethos in the mental health services and outlined the key aspects for consideration in the roll out of

such an initiative. The mental health services of the Mid West are to be commended for their dedication to continuously seeking to improve the delivery of mental health services in the Mid West and this research reflects the on-going commitment to supporting recovery based initiatives. Review and implementation of the recommendations of this report will ensure that the service continues to meet the changing needs of those involved in the mental health services and moves closer to achieving the vision of a holistic and responsive service for all.

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8.   Appendices

Appendix I   Survey

Ari Mid-West Recovery College E-Survey

1.   About You

(a) Age: Please indicate your age by ticking one of the below:

18 – 25 ☐   26 – 35 ☐   35 – 50 ☐   51 – 65 ☐   66+ ☐

(b)   Male ☐   Female ☐

(c) What region of the Mid-west do you live in?

Limerick ☐   Clare ☐   Tipperary ☐   Other ☐

(d) What is your primary connection to the mental health services in your area (Please tick all that apply):

Service User   ☐

Staff member   ☐

Professional in a related organisation   ☐

Friend of a service user   ☐

Family member of a service user   ☐

Experience of mental ill-health   ☐

Volunteer   ☐

General Public   ☐

(e) If you are a staff member please tell us your position and role in supporting service users?

_____

_____

_____

2.   Recovery

We are interested in measuring your beliefs about the concept of recovery from mental illnesses.
Please read each of the following statements and using the scale below mark the rating that most closely matches your opinion.

SA Strongly Agree	A Agree	U Unsure	D Disagree	SD Strongly Disagree	NR No Response

(a)   People in recovery sometimes have set backs. . . . . **SA   A   N   D   SD   NR**

(b)   To recover requires faith. . . . . **SA   A   N   D   SD   NR**

(c)   Stigma associated with mental illness can slow down
the recovery process. . . . . **SA   A   N   D   SD   NR**

(d)   Recovery can occur even if symptoms of mental illness
are present. . . . . **SA   A   N   D   SD   NR**

(e)   Recovering from mental illness is possible no matter
what you think may cause it. . . . . **SA   A   N   D   SD   NR**

(f)   All people with serious mental illnesses can strive for
recovery. . . . . **SA   A   N   D   SD   NR**

(g)   People differ in the way they recover from a mental
illness. . . . . **SA   A   N   D   SD   NR**

(h) In your own words please outline what you think Recovery is?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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3. Training and Education

A Recovery College:

- Provides a base for recovery resources

- Promotes an educational and coaching model in supporting people to become experts in self-care on their recovery journey

- Breaks down barriers between 'us' and 'them' by offering training sessions run for and by people with experience of mental health or physical health challenges and people with professional experience

(a) What role do you think training and education has in the recovery process?

_____
_____
_____
_____
_____
_____

(b) If training and education was provided in a Recovery College what would you consider to be the three most important topics?

(i)_____

(ii)_____

(iii)_____

(c) Location:

Where would you like Recovery College courses to be delivered?

_____
_____
_____
_____
_____
_____

(d) What do you think would be most important to consider in developing a Recovery College?

(i)_____

(ii)_____

(iii)_____

(e) Have you any suggestions for us in developing a Recovery College?

_____

_____

_____

_____

(f) Please feel free to make any additional comments you think are necessary?

_____

_____

_____

_____

I would like to withdraw from this survey please ◯

Appendix II   Focus Group Script

Participant Interview Script
Advancing Recovery in Ireland, Recovery College Needs & Resource Analysis

The purpose of this research project is to understand your personal experience of mental health difficulties and your experience of attending the services. As you know we are exploring the potential of a mental health recovery college in the Mid-West and we would like to also explore your opinions in relation to this.

Before we begin:

- To ensure that we aren't disturbed during the interview I am going to turn off my mobile phone. Can you do the same? We should not be disturbed during the interview but if we are, I will turn off the voice recorder to deal with the interruption.

- Feel free to interrupt or ask for more information and let me know if you need to take a break during the interview.

- If I take notes during the interview it is form me to use as a prompt as part of a question – to assist my memory

- I am interested in your opinions and personal experiences; there are no right and wrong answers to the questions.

Is that ok?

Again, can I please have your permission to record this interview?

To start, can you tell me a little bit about yourself, your name, where you live, your age etc?

Personal Experiences
- Tell me about your experience of mental health difficulties?
- When did it start?
- What type of help did you receive?
- Were you ever hospitalised?
- What was that like?

Experience of Services
- Tell me about your experience of the mental health services?
- Did you attend a day hospital?
- What healthcare professionals did you meet/work with?
- What are the positive parts of/good things about the service?
- What are the parts of the service that you would like to change?
- In what way?

Experience of Peer Support
- Sometimes people receive support from others who have experienced mental health difficulties, it's called peer support, has this been part of your recovery?
- Where did you receive this type of support, how did you access this support?
- What has been helpful about this?
- What do you think of this idea?

Recovery College
- Are you aware that we are exploring the concept of a recovery college in the Mid-West?
- What do you think about this idea?
- Do you think that a recovery college would have changed your experience of mental health difficulties and the services? How?
- Where do you think would be a good place to locate the recovery college?
- What courses/types of courses should be included?
- Who are the people who should be involved in delivering the programmes at the college?

Script Focus Group
Advancing Recovery in Ireland, Recovery College Needs & Resource Analysis

The aim of the focus group is to elicit discussion on the potential of developing a mental health recovery college in the Mid West.

Hello everyone and thank you for coming today to participate in our focus group. I will be asking you some questions for you to discuss as a group and my role will be to guide the discussion as we go on. Remember, there are no right answers and no wrong answers. We want to hear about your experience and your thoughts.

The session will be digitally recorded. I would ask you to turn off your mobile phones before we begin. Also when we are talking in the group we would like one person to speak at a time.

Before we begin our discussion I want to spend a few moments talking about confidentiality and to go over some basic ground rules for our focus group discussion today.

- Everyone's views are welcome and important
- The information that we will collect today will be connected to you **as a group**
- We will not identify quotes or ideas of any one person of this group
- Anything heard in the room should stay in the room
- It is important that we hear everyone's opinion so I will step in if too many people are talking at the same time to make sure everyone has a chance to speak
- I may step in if I feel the conversation is straying off topic.

Is that ok?

As you are aware we are here to discuss the potential of developing a mental health recovery college in the Mid West and we would like to hear your opinions and ideas

in relation to this. Has everyone read the information sheet? Are you comfortable with what a recovery college is and what its ethos is? Would you like me to explain it again?

Ok we'll begin….

Focus Group Questions

Service Users/People with Self Experience

- What are your opinions on that?
- Would you come?
- Is there anything else that you think that we have not covered that you would like to add?
- What would you like a recovery college to be about?
- Who should it be for? Who can it meet the needs of?
- What would be the most important aspect of a recovery college?
- Should the college be just about education or should there be other elements to it? What?
- How would a recovery college help you/others?
- How can it meet the needs of the staff of the mental health services?
- What do you think should be included? What types of courses would you like to see in a recovery college?
- What shouldn't be included in the college programmes?
- What groups (community or statutory) already run recovery based programmes well? What is it that they do well? How can we learn from them?
- What format should the courses take? (classroom? discussion group? activities? online? All of the above?)
- Who should run/deliver the programmes?
- Should courses be co-facilitated?
- Would facilitators need training? What type?
- Would the idea of having to do training put some people off?
- Where should the college be located?
- What resources does it need?
- How would the recovery college relate to existing services/statutory mental health services?

Families/carers/friends
(As above and the following)
- What are the particular needs of families/carers/friends that can be met by a recovery college?
- What could/should your input be into a project like this?

- What are your expectations in relation to what you might contribute to/gain from attending?

Staff

(As above and the following)

- What is your experience of the concept of recovery to date? How does it impact on your practice?
- What are the particular needs of staff that can be met by a recovery college? Are there particular programmes that should be run for staff?

Is there anything that we forgot or something important that we should know about?

Thank you all very much for taking part.

At the end of the focus group the facilitator will request that the note taker reflect the main themes of the discussion

Appendix III   Consent Form

Participant Informed Consent Form - Interview:
Advancing Recovery in Ireland – Needs and Resource Analysis

I, _____, am invited to take part freely in a research study exploring the potential of establishing a mental health recovery college in the Mid West.

- I have read and understand the participant information sheet.

- The purpose of this research is to explore the potential benefits and challenges associated with the development of a mental health recovery college in the Mid West.

- My participation and responses will be kept private at all times. I will not be identified, nor will identifying information about me be reported in any publications or presentations arising from the research.

- I agree that what I say can be included in talks or papers about this research as long as my name is kept private.

- If I agree to participate, I can withdraw at any time without explaining why. It won't affect the work if I choose to stop taking part.

- If I do withdraw from the study it will have no adverse affects for me

☐ I agree that my interview/focus group can be recorded.

☐ I agree to take part in 1 interview/focus group

☐ I would like to have a summary of my interview/focus group; sent to me or emailed to me ☐

I UNDERSTAND THAT BY SIGNING THIS FORM I AM GIVING MY CONSENT TO TAKE PART IN THE STUDY DESCRIBED ABOVE

I was given a copy of this form to keep

Signature of Participant _____ **Date** _____

Printed Name _____

Signature of Researcher_____ **Date** _____

Printed Name _____