The route to employment:

the role of mental health recovery colleges

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& James Kempton

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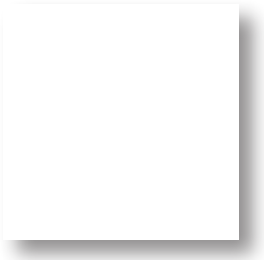

About the authors

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Executive summary

Unemployment has a profound impact on people with mental health problems. Working is the most important means of achieving economic resources; meeting individual psychosocial needs and is central to individual identity, social roles and status. But for people living with a mental health problem, work can also provide an important mechanism to improve health and wellbeing and to stay well. For this reason we need to get much better at tackling the levels of unemployment found amongst people with mental health problems.

Despite this, people with mental health problems face numerous disadvantages in making the transition from economic inactivity into work. They are overrepresented among the unemployed and in the secondary labour market. In order to address these issues, the barriers that prevent a person from becoming economically active and those which stop people gaining employment must be addressed, as the longer people are out of work, the less likely they are to ever return.

There are a number of government funded programmes aimed at helping people into work, by focusing on the issues around employability, access and sustainability. However, we know that focus should be placed equally on first helping people with mental health problems become economically active.

Recovery colleges are mental health services with the specific purpose of inspiring hope through their culture, environment and relationships; enabling people to take control of their lives; and facilitating access to opportunities. Since the idea was first brought to the UK in 2010, the model has quickly gained traction and there are around 28 recovery colleges in England, though many of these are still very new institutions.

In light of these issues, this paper seeks to understand the barriers that prevent people with mental health problems making the transition from

economic inactivity into work, looks at the current programmes put in place by government to support this journey and considers the distinctive role played by recovery colleges, one of the newer interventions in this space.

The rate at which the recovery college model has been taken up suggests that they are effective for users and meet an important need. Initial evidence points to the uniquely educational approach of recovery colleges within secondary mental health services as having significant potential for impact on improving employment outcomes.

This paper argues that recovery colleges should therefore increase their focus on these employment outcomes, supported by more rigorous and systematic evaluation of the overall impact of the model.

Recommendation 1: Courses offered by recovery colleges should be relevant and accessible to students at different stages of their recovery journey.

Recommendation 2: Education and employment outcomes (both in terms of achievement and/ or progression towards them) should be written into any recovery intervention.

Recommendation 3: Recovery colleges should offer signposting and progression routes to other education and employment focused interventions e.g. volunteering, individual placement support, further education colleges and higher education.

Recommendation 4: All recovery colleges should publish annual performance/impact data, including students' education and employment outcomes.

Recommendation 5: There should be a national evaluation of the recovery college model, which should include an examination of the impact being made on education and employment outcomes.

1 Introduction

Unemployment has a profound impact on people with mental health problems. Working is the most important means of achieving economic resources; meeting individual psychosocial needs and is central to individual identity, social roles and status.[1] But for people living with a mental health problem, work can also provide an important mechanism to improve health and wellbeing and to stay well. For this reason we need to get much better at tackling the levels of unemployment found amongst people with mental health problems.

This paper seeks to understand the barriers that prevent people with mental health problems making the transition from economic inactivity into work. It looks at the current programmes put in place by government to support this journey and considers the distinctive role played by recovery colleges, one of the newer interventions in this space. The rate at which recovery colleges have been commissioned suggests that they are effective for users and meet an important need. Initial evidence points to the uniquely educational approach of recovery colleges as having significant potential for impact on improving employment outcomes. The paper argues that recovery colleges should therefore increase their focus on these outcomes, supported by more rigorous and systematic evaluation of the overall impact of the model.

The importance of work

Work is a central part of life, offering an income; keeping people physically and mentally active; providing social contacts and skills; structuring and occupying our time; and offering social status, a sense of identity and personal achievement.[2] Work matters for everyone but is particularly

1 G Waddell and A Burton, 'Is work good for your wellbeing?', Department for Work and Pensions, 2006.
2 Ibid.

important for people with mental health problems as they can often feel socially excluded, with more than half of people likely to have poor social contact, compared with six per cent of the general population.[3]

Work can also prove an important mechanism for people living with a mental health problem to stay well, providing the working environment is positive. Those who have high levels of wellbeing at work are more productive and report greater job satisfaction; but employees experiencing a negative working environment are more likely to develop work-related stress and illness.[4] [5] However, this is a complex issue and the transition period between unwell to well or sick to healthy can be arbitrary. It is really about personal recovery and readiness to work.

As employment is a major driver of the social gradients of physical and mental health mortality, it is essential we address this issue. [6]

Long term unemployment is also very costly to society. It is estimated that mental health problems cost the UK economy £26 billion each year, with the majority of the costs (£15.1 billion) caused through lost productivity, followed by £8.4 billion lost through sickness absence and £2.4 billion lost through staff turnover.[7]

Unemployment rates and economic activity

In the United Kingdom, 73 per cent of people of working age are currently in work, equating to 30.79 million people. Only six per cent of the economically active population (those seeking and available to work) are unemployed and this figure is continuing to fall.[8]

Conversely, the proportion of the working age population who are economically inactive (not seeking or available to work) is currently 22.2 per cent, equating to 9.03 million people.[9] Of these almost a quarter are economically inactive because of a health condition, of which 22

3 Scottish Association Mental Health, 'A World to Belong to: Social Networks of People with Mental Health Problems', SAMH, 2006.
4 C van Stolk, J Hofman, M Hafner et al., 'Psychological Wellbeing and Work. Improving Service Provision and Outcomes', RAND Europe, January 2014.
5 K Paul and K Moser, 'Unemployment Impairs Mental Health: Meta-Analyses', Journal of Vocational Behavior, 2009, 264–282.
6 G Waddell and K Burton, 'Is Work Good for Your Health and Wellbeing?' London: The Stationery Office, 2006.
7 Ibid.
8 Office for National Statistics (ONS), 'UK Labour Market', November 2014, available from: http://www.ons.gov.uk/ons/rel/lms/labour-market-statistics/november-2014/statistical-bulletin.html
9 From this group, 26 per cent are full time students, 26 per cent are looking after family or their home, 14 per cent have retired and a further 11 per cent are economically inactive for other reasons.

per cent are have a condition which has prevented them from entering the workforce for more than four weeks, also known as long term sick.[10] Furthermore, the proportion of people who are economically inactive appears to have been insusceptible to government initiatives over recent years and has neither increased nor decreased.

People with mental health problems and work

People with mental health problems face numerous disadvantages in making the transition from economic inactivity into work. They are overrepresented in the secondary labour market.[11]

For instance, people with mental health problems in work are more likely to be underemployed (i.e. they are doing less hours than they would like or they are over qualified for their role) and employed in low paid or low status jobs.[12]

Like many other long term health conditions, mental health problems range in severity, often graded as mild, moderate or severe. Even for those with a common mental disorder – such as depression or anxiety – 63.7 per cent are out of work.[13] For those in contact with secondary mental health services (i.e. those with severe mental health problems that require specialist care from hospital, the community or specialist teams), 94.7 per cent are out of work.[14] However, this figure is variable across the country with as many as 99.3 per cent of people out of work in some areas and as low as 81.7 per cent in others.[15] Further to this, people with mental health problems accounted for up to 38 per cent of all new claims to disability benefit in 2011, and are strongly represented in other working-age benefits, such as income support and housing benefit.[16]

The government's position is clear: more people need to enter the workforce and in the past five years, the Work Programme, Access

10 ONS, 'UK Labour Market', October 2014, available from: http://www.ons.gov.uk/ons/rel/lms/labour-market-statistics/october-2014/statistical-bulletin.html#tab--i--Summary-of-latest-Labour-Market-Statistics
11 The secondary labour market is the labour market consisting of high-turnover, low-pay and usually part-time or temporary work.
12 S Stuart, 'Mental illness and employment discrimination', Current Opinion in Psychiatry, 2006, 19: 522526.
13 Health and Social Care Information Centre, 'Employment of people with mental illness', November 2014, available from: https://indicators.ic.nhs.uk/webview
14 Health and Social Care Information Centre, 'Proportion of adults in contact with secondary mental health services in employment', December 2014, available from: https://indicators.ic.nhs.uk/webview/
15 H Taggart, 'CentreForum Atlas of Variation: identifying unwarranted variation across mental health and wellbeing indicators in England', CentreForum, July 2014.
16 OECD, Mental Health and Work, 2014.

to Work, Jobcentre Plus and other initiatives have tried to reduce unemployment rates. There has also been a focus on vulnerable groups to labour market exclusion: young people, offenders, those with disabilities and people with mental health problems. For mental health problems in particular, the 'No Health Without Mental Health' implementation strategy, published in 2011, set out a clear ambition in order to help people enter, stay and return to employment.[17] Four years later, it seems that people with mental health problems remain disadvantaged by the labour market, despite success being observed in other vulnerable groups.[18] As a result, employment issues and helping people back into work is a key priority of the government's Mental Health Taskforce.[19]

Structure and methodology

The report begins by considering the many barriers to work faced by people with mental health problems. Chapter 3 moves on to examine the effectiveness of current schemes and programmes designed to address these barriers. The report then describes (Chapter 4) the emerging recovery college model and looks (Chapter 5) at their role in delivering employment related outcomes and whether they could make an enhanced contribution to this. In doing so it refers to evidence taken from the most established recovery colleges which is summarised in the Appendix. Finally the report presents its conclusions and recommendations in Chapter 6.

The methodology for this paper comprised of a literature review relating to the barriers to employment faced by people with mental health problems. We also analysed the prospectuses of the most mature recovery colleges in England.

17 HM Government, 'No Health Without Mental Health', February 2011.
18 Labour Force Survey, 'LFS National and Regional Indicators for Aug-Oct 2008', 2008.
19 Gov.UK, 'Mental health Taskforce announced', 2015, available from: https://www.gov.uk/government/news/mental-health-taskforce-announced.

2 Addressing the barriers

It is evident that a disproportionate number of people with mental health problems are out of work. In order to reduce this gap, the barriers that prevent a person from becoming economically active and those which stop people gaining employment must be addressed.[20] Making the transition from not seeking or available to work to actively searching for employment is complex. The longer people are out of work, the less likely they are to ever return.[21] [22] There are a number of entry points into the system and not everyone will need the same level of intensity of support.

Economically inactive to economically active

Some people with mental health problems are not ready for paid employment and need support in addressing the barriers that prevent them from working. Challenges to overcome include: improving mental health so that a person is well enough to work; addressing low and expectations and personal recovery; becoming work-ready and obtaining the core education and skills needed for work.

Clinical recovery

In England, one in six adults experience a common mental disorder at any one time and two per cent of the population experience a serious mental illness such as schizophrenia, psychosis or bipolar affective disorder.[23] Mental and behavioural health problems contribute significantly to the global burden of disease in the UK, accounting for 23% of the total years of life lived with disabilities and can affect a person's life chances in a

20 Centre for Mental Health, 'Barriers to employment: what works for people with mental health problems?' Briefing 47, September 2013.
21 Mental Health Foundation and Loughborough University, 'Returning to work: role of depression', 2009.
22 K Burton and G Waddell, 'Health and Work', Royal College of Psychiatrists, 2007.
23 Health and Social Care Information Centre, 'Adult Psychiatric Morbidity in England – Results of a Household Survey', January 2009, available from: www.hscic.gov.uk/pubs/psychiatricmorbidity07

number of ways.[24]

It is difficult to predict how long an illness will last but typically, half of all people diagnosed with a common mental disorder tend to recover after 18 months; whereas in people diagnosed with schizophrenia or psychosis, around 25 per cent of people will recover following their first episode, 10-15 per cent will experience long-term difficulties and the remainder will experience recurrent episodes.[25] Although, recovery rates differ depending on treatment and social circumstances, and clinical recovery is not dependent on being able to work in all cases.

Personal recovery

Beyond a reduction in clinical symptoms, personal recovery involves the development of new meaning and purpose in one's life.[26] Recovery can be defined as 'a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Central to a recovery approach is restoring feelings of hope, control and opportunity into the lives of people with mental health problems.[27]

One of the reasons why people with mental health problems do not make the transition to economically active is because they have lost a sense of agency over their lives, and with this, a feeling of hope and opportunity for the future. These feelings are often reinforced by our health system, which places greater emphasis on treatment and intervention as opposed to prevention and promotion of ill health.

A culture of low expectations in terms of employment within parts of the NHS sometimes provides little encouragement. One study found that clinicians believed that people with schizophrenia are only capable of non-competitive work such as volunteering.[28] We need to move away from this culture and help people build a life beyond mental illness.

24 Institute for Health Metrics and Evaluation, 'GBD heat map', 2010, available from: www.healthmetricsandevaluation.org/gbd/visualizations/gbd-heatmap

25 E Halliwell, L Main and C Richardson, 'The Fundamental Facts', Mental Health Foundation, 2007.

26 W Anthony, 'Recovery from mental illness: the guiding vision of the mental health system in the 1990s', Innovations and Research 1993; 2:17-24.

27 South London and Maudsley NHS Foundation Trust and South West London and St George's Mental Health NHS Trust, 'Recovery is for All. Hope, Agency and Opportunity in Psychiatry. A Position Statement by Consultant Psychiatrists'. SLAM/SWLSTG, 2010.

28 S Bevan, J Gulliford, K Steadman, et al., 'Working with Schizophrenia: Pathways to Employment, Recovery & Inclusion'. The Work Foundation, 2013.

Work readiness

A recent report suggests that there are six essential capabilities that people need to demonstrate in order to find and maintain a job.[29] These include being:

- **Self-aware -** Take responsibility for themselves and others, exhibit self-control, accountability for one's actions, does not shift blame and recognises their own strengths and weaknesses.
- **Receptive -** Has good levels of self-esteem, willing to ask questions and seek more information, can work alone without clear direction, display physical signs of self-esteem such as a firm handshake.
- **Driven -** Willing to address weaknesses, takes feedback and advice, open to new ideas and working in different ways, open-minded, patient and flexible.
- **Self-assured -** Copes with rejection and set-backs, learns from mistakes, open to constructive criticisms, determined to overcome obstacles, perseveres and does not panic under pressure.
- **Resilient -** Displays a positive attitude, applies oneself consistently, reliable, motivated, punctual, well-organised, and hard-working and goes the extra mile.
- **Informed -** Has an understanding of the job market, able to search for job vacancies, does background research, understands office etiquette, well-presented, can effectively describe their achievements verbally and has a representative CV.

Many people with mental health problems may experience difficulties in overcoming these barriers as the nature of some mental health problems means that they experience a lack of motivation, stamina, confidence and self-esteem.[30] For those who have been unemployed for some time, they may also have a lack of awareness of employers' expectations.

Education, skills and work experience

In the UK, there is an overwhelming association between poverty, deprivation and adverse mental health outcomes.[31] A consequence of pover-

29 Impetus, 'Ready for Work', September 2014.
30 NHS Scotland, 'Healthy Working Lives', 2012, available from: www.healthyworkinglives.com/advice/employability/what-is-employability.aspx#definition.
31 I Goldie, J Dowds and C O'Sullivan, 'Mental health and inequalities', Mental Health Foundation, Background Paper 3, 2013.

ty is often poor education attainment, of which there is a bidirectional association between education and adverse mental health outcomes. For instance, those experiencing social disadvantage are 2.5 times more likely to have a mental health problem and low educational attainment is a risk factor for both individuals and communities.[32] Likewise, those with a mental health problem in the early years of life – such as conduct disorder – are twice as likely to leave school without any qualifications.[33] Bullying in schools is associated with mental health problems, feelings of loneliness, loss of interest in activities they used to enjoy as well as reduced academic attainment.[34]

Volunteering is a popular way of gaining work experience and getting back into working life. Volunteering is about not only helping vulnerable or marginalised people but also empowering them to become active in the community, build skills and confidence and increase their options whilst making a difference.[35]

Economically active to employed

The previous section focused on the barriers that people with mental health problems may face when making the transition from economically inactive to active. This section focuses on how people with mental health problems who are available and actively seeking work can be supported to find and maintain paid employment.

As people with mental health problems are more likely than any other group with disabilities to want to have a job, this is an important area of focus. According to a survey that found that 90 per cent of respondents said they would like to work, compared with 52 per cent of disabled people generally.[36]

To achieve this, the following barriers must be overcome: fear of discrimination; employability; access to work and sustainability of available employment.

32 V Murali and F Oyebode, 'Poverty, Social Inequality and Mental Health'. Advances in Psychiatric Treatment, 2004, 10: 216-224.

33 M Parsonage, L Khan and A Saunders, 'Building a better future: the lifetime costs of childhood behavioural problems and the benefits of early intervention', Centre for Mental Health, 2014.

34 Stopbullying.gov, 'Effects of bullying', 2014, available from: http://www.stopbullying.gov/at-risk/effects/

35 Community Service Volunteers (CSV), 'Supporting People with Disabilities to Volunteer', 2013, available from: http://www.csv.org.uk/volunteering/supported

36 J Secker, B Grove and P Seebohm, 'Challenging barriers to employment, training and education for mental health service users: the service user's perspective'. Journal of Mental Health, 2001, 10 (4) 395-404

Discrimination

Both actual discrimination and anticipated discrimination (the belief that they are likely to face discrimination) are important barriers to address. Discrimination against people with mental health problems can be witnessed at a societal, workplace and individual level. One survey found that half of employers would not hire someone who has a history of a mental illness.[37]

This is not surprising as 92 per cent of the general population believe that disclosing a history of mental health problems to an employer would damage a person's career.[38] [39] The impact of this has resulted in people with mental health problems stopping themselves applying for work, education or training for fear of discrimination related to their mental health problem. Over time, it can adversely affect a person's confidence leading them to doubt their ability to work at all.[40]

Further to this, a survey conducted as part of the CentreForum Mental Health Commission found that 63 per cent of service users said they had been treated unfairly in finding a job and 67 per cent of service users said that they had been treated unfairly in keeping a job.[41]

The Time to Change anti stigma campaign is a government funded initiative that aims to eliminate mental health stigma and discrimination in England and aims to change behaviour, rather than just attitudes. It provides information on disability discrimination in the workplace.[42]

Employability skills

Employability can be defined as 'the knowledge, skills, attitudes and behaviours required to seek, obtain and sustain employment at all levels in the labour market, employment, and obtaining new employment if required'.[43]

37 Chartered Institute of Personnel and Development (CIPD), 'Labour Market Outlook: Quarterly Survey Report', 2007.
38 Rethink, 'Fear of Stigma Stops Employees with Mental Health Problems from Speaking out'. YouGov Poll, 2010.
39 Time To Change, 'Stigma of Mental Health Makes Finding Work in Recession More Difficult'. YouGov Poll, 2009.
40 P Lelliott, S Tulloch, J Boardman, et al., 'Mental Health at Work', Royal College of Psychiatrists, March 2008.
41 H Taggart and T Rathborn, 'Call for evidence: summary of key findings', CentreForum, July 2014.
42 Time to Change, 'Who are we', 2015, available from: http://www.time-to-change.org.uk/about-us/what-is-time-to-change
43 J Hillage and E Pollard, 'Employability: developing a framework for policy analysis'. Department for Education and Employment, 1998.

According to the CBI, there are eight top employability skills including:

- Self-management,
- Team working,
- Problem solving,
- Communication – application of literacy,
- Business awareness,
- Customer care,
- Application of numeracy,
- Application of ICT.[44]

People who have been unemployed for some time due to poor health will need to update their employability skills.

Employment sustainability

Once in work, people with mental health problems may need support to sustain and retain their job. This is particularly important as those who experience a poor working environment are more likely to develop work-related stress and relapse. This may include inflexible working hours, difficult relationships, high workloads and high expectations.[45]

This chapter has shown that significant barriers exist for people with mental health issues in moving from economic inactivity to economic activity and then onto employment. The next chapter looks at ways to address the challenge of overcoming these barriers.

44 CBI, 'Time well spent: Embedding employability in work experience', 2007.
45 G Waddell and K Burton, 'Is Work Good for Your Health and Wellbeing?', 2006.

3 Work schemes

As the previous chapter has shown, people with mental health problems face considerable barriers to making the journey to employment, even once they feel ready to work. This chapter examines the current government schemes and programmes designed to support this process (see also Figure 1).

Jobcentre Plus

Jobcentre Plus is a universal service to help people prepare for, find and stay in work. This includes training, guidance and work placement programmes; work experience, volunteering and job trialling schemes; help with starting your own business; help combining work with child care or other caring responsibilities; and extra help for specific problems.[46] People with mental health problems can access specialist advice from a Disability Employment Advisor.

Work Programme, Work Choice, Access to Work

Anyone who is found fit for work through the Work Capability Assessment, those put into the Work Readiness Action Group (WRAG) of Employment and Support Allowance and people who have claimed Job Seekers Allowance for three months are usually mandated to the Work Programme.

The Work Programme gives providers wide scope to find their own creative and individualised support options for people with any disability or need which may place them at a disadvantage in the labour market. Employment support is funded through staged payments which the Work Programme provider draws down at engagement, job entry and successive points of job retention.[47]

46 Gov.UK, 'Help with moving from benefits to work', 2015 available from: www.gov.uk/moving-from-benefits-to-work
47 Ibid.

Work Choice aims to help people with a disability to find a job. It is a voluntary scheme and the type of support offered depends on the help needed but can include training and developing skills; building confidence and interview coaching. An Access to Work grant can pay for practical support for those with a disability, health or mental health condition to get into work, start working, stay in work, move into self-employment or start a business. The grant is not for business start-up costs. The money does not need to be paid back.

However, the current Work Programme and Work Choice has failed to support people with mental health problems get into work. Of the 126,000 people on the Work Programme, only 5,500 people with mental health problems have managed to find a place in sustainable employment (4.4 per cent).[48] Also, from the 82,370 people living with a disability who have started Work Choice, 11,680 have mild to moderate mental health problems (14 per cent) and 690 people have a serious mental illness (0.8 per cent). What's more, of the 32,400 people who have acquired a job through Work Choice, 5000 have mild to moderate mental health problems (15.4 per cent) and 260 people have a serious mental illness (0.8 per cent). It appears that a targeted approach is more effective.[49]

48 Mind, 'Our Work on Benefits', 2014, available from: http://www.mind.org.uk/about-us/policies-issues/benefits/

49 Department for Work and Pensions, 'Work Choice: Official statistics', February 2015, available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/402378/work-choice-statistics-feb-2015.pdf

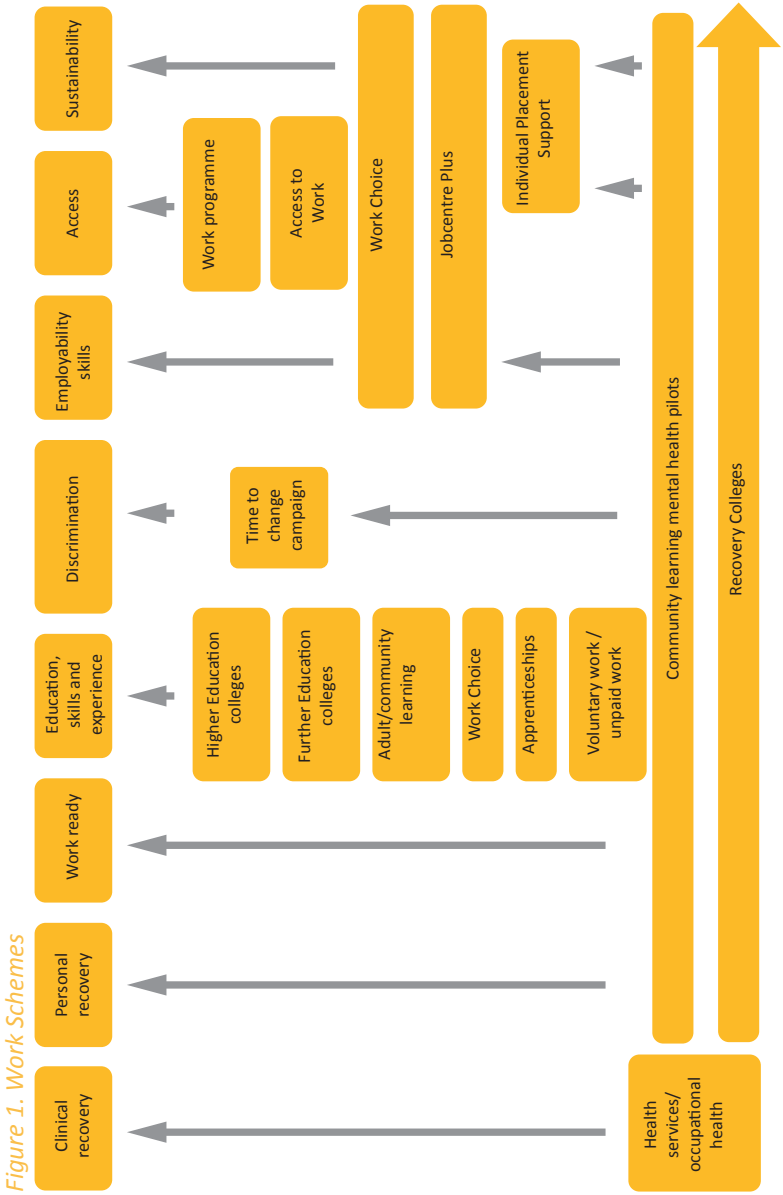

Figure 1. Work Schemes

Individual placement support

Individual placement support (IPS) is a 'place then train' model targeted at people with mental health problems who want to get a job. This involves getting people into competitive employment first, and then providing training and support on the job: 'place then train'. The most well-established, most effective and best evidenced 'place then train' intervention in mental health is Individual Placement Support (IPS). This follows these eight principles:

1. It aims to get people into competitive employment,
2. It is open to all those who want to work,
3. It tries to find jobs consistent with people's preferences,
4. It works quickly,
5. It brings employment specialists into clinical teams,
6. Employment specialists develop relationships with employers based upon a person's work preferences,
7. It provides time unlimited, individualised support for the person and their employer,
8. Benefits counselling is included. [50] [51]

A randomised controlled trial across six European countries of 312 people with serious mental illness found people accessing IPS are twice as likely to gain employment and work for significantly longer (55 per cent), compared to those who attending a standard vocational programme (28 per cent). The total costs for IPS were also generally lower than standard services over first six months; and individuals who gained employment had reduced hospitalisation rates. [52]

IPS is aimed at people who are ready for paid employment, rather than those needing support to become economically active so it is not suitable for everyone. Evidence also suggests that IPS tends to lead to part time entry level jobs.[53]

50 Centre for Mental Health, 'Doing what works: Individual placement and support into employment', 2009.

51 Centre for Mental Health, 'Implementing what works: the impact of Individual Placement Support', 2012.

52 T Burns, S White, J Catty et al., 'Individual Placement and Support in Europe: The EQOLISE trial'. International Review of Psychiatry, 2008 20(6), pp.498-502.

53 P Lelliott, S Tulloch, J Boardman, et al., 'Mental Health at Work', Royal College of Psychiatrists, March 2008.

New initiatives – pilot studies

The government is supporting a number of new initiatives to improve education and employment services for people with mental health problems. It has announced £12 million to test whether better coordination of mental health and employment services could help people with mental health problems find and stay in employment as well as improve their mental health across four pilot areas. Different approaches include:

- Key workers and individual support packages to help claimants create bespoke action plans and coordinate existing local support services.
- Support for new employees to make sure they can stay in work and cope with anxiety and other ongoing problems.
- Training employment advisers to identify mental health problems and for GPs to recognise the importance of work in improving mental health.[54]

Another pilot study is testing whether the evidence-based IPS approach can be adapted from specialist mental health services to primary care for people with anxiety and depression. It aims to provide people who are out of work and have common mental health problems with psychological therapy alongside help from an employment specialist.[55]

Furthermore, the government's 2014 Autumn Statement announced an additional investment of £20 million for pilot community learning courses to help adults recover from mild to moderate mental health problems, such as depression, anxiety and sleep disorders. The pilots sponsored by the Department for Business Innovation and Skills and supported by the Department of Health and NHS will aim to help up to 80,000 learners across England and the supporting evidence makes a strong case for investment. [56] An evaluation of adult learning initiatives found that participation was associated with reductions in self-reported depression, improvements in reported life satisfaction and happiness, improvements in self-confidence, improvements in own perceptions

54 Gov.UK, '£12 million to help people with mental health problems get back into work', December 2014, available from: https://www.gov.uk/government/news/12-million-to-help-people-with-mental-health-problems-get-back-into-work.

55 Centre for Mental Health, 'Centre for Mental Health begins work to offer more people best available help with employment', October 2014, available from: http://www.centreformentalhealth.org.uk/news/2014_IESD_employment_project.aspx.

56 Skills Funding Agency, 'Community Learning Mental Health Pilot: specification', January 2015.

of self-worth, increases in satisfaction with social life and increase in satisfaction with use of one's leisure time.[57]

As this chapter has illustrated, many of the government funded programmes aimed to help people into work are focused on the issues around employability, access and sustainability. However, we know that focus should be equally placed on helping people with mental health problems become work ready. In light of these issues, the following chapter considers the role recovery colleges can play across all of these barriers.

57 P Dolan, D Fujiwara and R Metcalfe, 'Review and Update of Research into the Wider Benefits of Adult Learning', Department for Business, Innovation and Skills, November 2012.

4 Recovery colleges

The first recovery college in England was set up in South West London and St George's in January 2010. The rate at which the model has been picked up since then suggests that recovery colleges are effective for users and meet an important need. This chapter explains what recovery colleges are and how they operate. It looks at how their educational approach to recovery differs from the more traditional therapeutic/day centre interventions. Appendix 1 sets out the key features of four of the most established recovery colleges.

Definition

Recovery colleges are services with the specific purpose of inspiring hope through their culture, environment and relationships; enabling people to take control of their lives; and facilitating access to opportunities. Whilst recovery colleges vary, there are defining features. These are:

- There is a physical base,
- It operates on college principles,
- It is for everyone,
- There is a Personal Tutor (or equivalent) who offers information, advice and guidance,
- The College is not a substitute for traditional assessment and treatment,
- It is not a substitute for mainstream colleges,
- It must reflect recovery principles in all aspects of its culture and operation,
- Learning is delivered by people with lived experience of mental health problems working alongside other professionals.[58]

58 R Perkins, J Repper, M Rinaldi et al., 'Recovery Colleges', Centre for Mental Health and Mental Health Network NHS Confederation, 2012.

Recovery colleges describe themselves as operating on college principles, and the student experience aimed for is more similar to that of Further Education (FE) colleges. That said, they do not offer GCSEs or other academic or substantial vocational qualifications, nor are they inspected as academic institutions.

Recovery theory

Recovery approaches in mental health care encompass ideas of strength, co-defined and co-produced recovery, self-management, rehabilitation and social inclusion and they are built on three principles: agency; opportunity and hope. Agency involves gaining a sense of control and finding personal meaning by drawing upon personal resources.

There are three models of mental health recovery: the Strengths Model; the Tidal Model of recovery; and the Wellness Recovery Action Plan. The Strengths Model works in opposition to a deficit model and focuses on individual strengths such as their achievement, successes, goals and aspirations.[59] [60]

The Tidal Model focuses on recreating the meaning of being 'ill' and encourages professionals to see the service user as an expert in their own illness and respecting of their wishes and beliefs. [61] Alternatively, the Wellness Recovery Action Plan focuses on self-help and allowing individuals to recognise triggers, early warning signs, coping strategies and what support is needed.[62] Recovery colleges incorporate these theoretical principles.

Purpose and remit

The recovery college initiative came from a desire to promote recovery by facilitating co-production between people with personal and professional experience of mental health problems and to help organisations become more recovery focused. In England, there are approximately 28 recovery colleges and many more in development (see Figure 2). There are also recovery colleges in the United States of America, Italy, Australia and Japan.

59 C A Rapp and R J Goscha, 'The Strengths Model: Case Management With People With Psychiatric Disabilities'; Oxford University Press, 2006.
60 Deficit models have an emphasis on assessment of need and diagnosis of various conditions.
61 P Barker and P Buchanan-Barker, 'The Tidal Model: A Guide for Mental Health Professionals', Routledge, 2004.
62 M Copeland, 'Wellness Recovery Action Plan', Peach Press, 2000.

Figure 2. Location of recovery colleges in England 2015

Whilst recovery colleges sit under the umbrella of mental health services, they are different from traditional services in that they employ an educational approach to recovery, rather than a therapeutic one. For instance, in traditional clinical settings, health information is passed from professional to patient through a 'psycho-educational' approach in order to improve symptoms or health states and encourage self-management. In contrast, an educational approach gives agency back to the individual, inspires hope and provides opportunities for the future above and beyond symptom management.

Co-production is a major part of this, particularly as recovery colleges employ people with lived experiences of mental health problems as 'peer workers' to teach courses. Therefore, through an educational approach to recovery there is a greater focus on wellbeing and quality of life. Table 1 demonstrates these differences.

Table 1. A therapeutic approach versus an educational approach[63]

A therapeutic approach	An educational approach
Focuses on problems, deficits and dysfunctions.	Helps people recognise and make use of their talents and resources.
Strays beyond formal therapy sessions and becomes the over-arching paradigm.	Assists people in exploring their possibilities and developing their skills.
Transforms all activities into therapies –work therapy, gardening therapy etc.	Supports people to achieve their goals and ambitions.
Problems are defined, and the type of therapy is chosen, by the professional 'expert'.	Staff become coaches who help people find their own solutions.
Maintains the power imbalances and reinforces the belief that all expertise lies with the professionals.	Students choose their own courses, work out ways of making sense of (and finding meaning in) what has happened and become experts in managing their own lives.

Further to this, it is evident that recovery colleges are not just rebranded day centres delivered by local mental health NHS Trusts. Table 2 identifies how the therapeutic versus educational approach works in practice.

63 R Perkins, J Repper, M Rinaldi et al., 'Recovery Colleges', Centre for Mental Health and Mental Health Network NHS Confederation, 2012.

Table 2. Differences between Day centres and Recovery Colleges[64]

From Day Centre	To Recovery College
Patient or client: *"I am just a mental patient".*	Student: *"I am just the same as everyone else".*
Therapist.	Tutor.
Referral.	Registration.
Professional assessment, care planning, clinical notes, review process.	Co-production of a personal learning plan, including learning support agreed by the student.
Professionally facilitated groups.	Education seminars, workshops and courses.
Prescription: *"This is the treatment you need".*	Choice: *"Which of these courses interest you?".*
Referral to social groups.	Making friends with fellow students.
Discharge.	Graduation.
Segregation.	Integration.

Target group served

Recovery colleges are aimed at three target groups: adults over the age of eighteen with mental health problems; carers and family members of those with mental health problems and professionals working at the NHS Trust attached to the recovery college.

While the recovery colleges are open to everyone with mental health problems, one study demonstrated that students on average had been using mental health services for six years and 45 per cent had a diagnosis of psychosis. The characteristics of the people who use recovery colleges are people with severe and enduring mental illnesses and have often been in contact with mental health services for approximately seven years.[65] Therefore, individual needs may relate to long-term unemployment, social isolation and a loss of hope, control and opportunity.

The number of students enrolled vary considerably. For example,

64 Ibid.
65 Ibid.

Nottingham Recovery College has 600 students enrolled whereas Central and North West London has over 1700 students. Numbers served by less well-established colleges are significantly lower.

Activities

From the recovery college prospectuses reviewed for this report it would appear that courses reflect the mission around hope, control and opportunity and fall into the following areas of study, though they will not necessarily offer something in every one of them:

- Understanding mental health issues and treatment options,
- Rebuilding life with mental health challenges,
- Developing life skills,
- Capacity building among the peer workforce,
- Family and friends (see Figure 3).

Figure 3. Hope, control and opportunity [66]

This chapter has described recovery colleges in terms of the theory, purpose and remit, target group served, coverage and activities implemented. The following chapter discusses the role of recovery colleges in delivering employment related outcomes.

66 South West London and St George's Mental Health NHS Trust, 'Prospectus 2014 – 2015', January 2014, available from: http://www.swlstg-tr.nhs.uk/_uploads/documents/recovery-college/reco-college-prospectus.pdf.

5 Discussion

The previous chapter described recovery colleges in terms of their purpose and remit, theory, target groups served, coverage and activities implemented. This chapter focuses more specifically on the role of recovery colleges in delivering employment related outcomes, particularly relating to taught courses, partnership working and the impact on employment related outcomes.

Courses relating to education, skills and employment

Table 3 summarises the courses available at seven of the most mature recovery colleges in relation to employment outcomes. From this we understand that, from those surveyed, all include courses relating to employment. However, they range in number, with 11 being the most courses offered and the least being two.

When considering taught courses in terms of the breadth of content, it is clear that courses are offered right across the employment journey. However, the majority of courses relate to employability skills followed by IT skills, discrimination and work readiness. There seems to be less focus on access to employment and support with retaining and sustaining work, through the use of IPS advisors. However, South West London and St George's Trust embed IPS workers within their taught course relating to 'Returning to Work and Study'.

It appears that many are short courses. The average session takes two hours. However, there a few exceptions where longer courses are offered over six weeks. Again, these tend to be half day sessions, once a week over six weeks. Furthermore, many of the courses are taught by professionals and peers employed by the college, rather than specialist advisors on employment. The Level 1 Certificate in Learning, Employability and Progression offered by Sussex Recovery College is the only example of a

formally accredited course identified through the course of our research.

Partnership working

While progression on to services offered by other providers can be a good outcome for some people, many who use recovery colleges may not yet be ready or resilient enough to make this transition. The recovery college model therefore offers the potential to join up interventions across the range of barriers identified in Chapter 2. A hub and spoke model is a good way to facilitate this.

Partnership working can play a key role in developing the recovery college offer in terms of increasing the range and depth of education and skills courses available and especially in supporting people with mental health problems moving from being economically active to being employed. For example Nottingham Recovery College works with educational establishments such as Central College Nottingham, the Workers Education Association and both its local universities. It also partners with Jobcentre Plus and the Department for Work and Pensions and third sector groups.

Personal tutors can play a key role in providing information about other opportunities and support if needed.

Impact on outcomes

The research for this report has uncovered limited evidence of formal evaluation of the recovery college model at institutional level, or by commissioners. Nor has there been a rigorous and systematic review of the model overall. The lack of evaluation to date is understandable given the immaturity of recovery college model but, for a report such as ours, this is a considerable limitation. Despite the limitations of the information available on impact, it is apparent that the courses provided and the environment in which they are provided are extremely beneficial to the students.

A pilot study of four recovery courses compared students to those who did not attend a course, at an 18 month follow up. They found:

- The majority (68 per cent) of students felt more hopeful for their future than they had at the start of their course,
- Most (81 per cent) had developed their own plan for managing their problems and staying well,

Table 3. Courses relating to employment outcomes

Recovery College	Courses offered						
	Work readiness	Education	Skills	Employability skills	Discrimination	Access	Sustainability
Central and North West London NHS Foundation Trust 1			Making friends with computers and getting online 1 day course Social media explained 1 day course	Making it work at work 5 ½ days	To tell or not to tell – what to say to your employer – half day		Surviving and thriving at work 1 day course
Mersey Care NHS Trust 2		Introduction to numeracy and literacy skills – half day over 6 weeks	Online support – half day	The job seekers toolkit – half day over 9 weeks Interview skills – half day Introduction to volunteer mentoring with addiction services – half day		Individual placement support	
North East London NHS Foundation Trust 3			Switch on to IT – 2 half days	Employment and study- recovery in action – 6 weeks half day session			

Nottinghamshire Healthcare NHS Trust 4	Resilience at work- half day Preparing to work- in partnership with Central College- half day Returning to learn –in partnership with WEA- half day Thinking of university – in partnership with Nottingham Trent University- half day Thinking of volunteering- half day course	Can Do Maths – in partnership with Central College- half day	Word Power – in partnership with WEA- half day	CV Writing – filling the gaps- half day Work Support- half day Employment: Recovery in action 5 full days	Disclosure at work - half day		Resilience at work (if in work)- half day
South London and the Maudsley NHS Foundation Trust 5				How to Complete a Limited Capability for Work Questionnaire (ESA50)- half day How to Use Social Media to Find A Job- half day Volunteering and Recovery- half day	Mental Health: Disclosure and Your Rights at Work- half day		
South West London and St George's Mental Health NHS Trust 6	Introduction to work and study 1 day			Returning to work and study 6 ½ days		Individual placement support	
Sussex Partnership NHS Foundation Trust 7				Work and wellbeing- half day Level 1 Certificate in Learning, Employability and Progression – qualification- half day			

- Those who attended more than 70 per cent of their scheduled sessions (67 per cent of those who started) showed a significant reduction in use of community mental health services. [67]

Recovery colleges also appear to have impacted on employment outcomes with up to 70 per cent of students going on to find work, become mainstream students or become a volunteer.[68]

Overall, we believe that recovery colleges have the capacity to do more in helping people access work for the following reasons: recovery colleges have the infrastructure, teachers have a relationship with their students and a mission to embrace the notion of employability as a legitimate and valued goal for the recovery process. To support this, it is now timely that more formal evaluation takes place, not least because commissioning bodies and other funders will need harder data then they currently have if the exponential expansion of the model is going to continue.

The previous chapter described recovery colleges in terms of their purpose and remit, theory, target group served, coverage and activities implemented. This chapter discusses the role of recovery colleges in delivering employment related outcomes, particularly relating to taught courses, partnership working and the impact on employment related outcomes.

Notes for table 3

1 Central and North West London NHS Foundation Trust, 'Prospectus Spring/ Summer term', January 2015, available from: http://www.cnwl.nhs.uk/wp-content/uploads/CNWL_RecoveryCollege_Prospectus_2015.pdf.

2 Mersey Care NHS Trust, 'Prospectus 2013', March 2015, available from: http://www.merseycare.nhs.uk/Library/info/imroc/RECOVERY%20WEB%20DOCUMENT.pdf

3 North East London NHS Foundation Trust, 'North East London Recovery College', September 2014, available from: http://www.nelft.nhs.uk/_documentbank/NELFT_Recovery_College_2014_15_Prospectus.pdf.

4 Nottinghamshire Healthcare NHS Trust, 'Nottingham Recovery College: Spring term prospectus', January 2015, available from: http://www.nottinghamshirehealthcare.nhs.uk/our-services/local-services/adult-mental-health-services/nottingham-recovery-college/

5 South London and Maudsley NHS Foundation Trust, 'Autumn/ Spring courses', September 2014, available from: http://www.slamrecoverycollege.co.uk/courses.html.

6 South West London and St George's Mental Health NHS Trust, 'Prospectus 2014 – 2015', January 2014, available from: http://www.swlstg-tr.nhs.uk/_uploads/documents/recovery-college/recocollege-prospectus.pdf.

7 Sussex Recovery College, 'All courses', January 2015, available from: https://www.sussexre-

67 R Perkins, J Repper, M Rinaldi et al., 'Recovery Colleges', Centre for Mental Health and Mental Health Network NHS Confederation, 2012.

68 Ibid.

coverycollege.org.uk/courses/all-courses.

6 Conclusion

People with mental health problems are disproportionately excluded from the labour market. This gap is discriminatory in nature and has a negative impact on quality of life, health outcomes and cost to society. Living with a mental health problem is not incompatible with work. Indeed, working is a protective factor and should be a key focus for mental health services.

This paper has explored the barriers that prevent people with mental health problems making the transition from economic inactivity into work. It has acknowledged universal, targeted and pilot government programmes that seek to support this journey but has argued that recovery colleges also have a significant role to play. While the available evidence for recovery colleges is limited, the rate at which they have been introduced suggests that they meet an important need and offer people something which is not available elsewhere.

Recovery colleges uniquely have the potential to play an important role in supporting mental health problems right across the spectrum of interventions from personal recovery, through to becoming economically active and as far as employment. As this paper makes clear, for many this is a long journey punctuated by many barriers. The suggestion made here that recovery colleges should increase their focus on improving employment outcomes, is designed to add to the core focus around personal recovery, recognising that education and employment outcomes are key for people of working age living with and recovering from mental health problems.

As the recovery model matures, there is significant scope for better integration with other education and employment focused interventions, such as volunteering, IPS, further education colleges and higher

education. This can only be in the interest of services users. Recovery colleges can assist this process by ensuring personal tutors have an awareness of and information about, possible progression routes so that they can signpost people appropriately.

Recovery colleges have grown up across the country in an unplanned way in response to professional interest and user need. Consequently coverage is patchy. Addressing this should be a priority. A second key step should be to improve the availability of performance and impact information on an institutional basis and to ensure that the model is subject to a formal and rigorous evaluation.

Recommendation 1: Courses offered by recovery colleges should be relevant and accessible to students at different stages of their recovery journey.

Recommendation 2: Education and employment outcomes (both in terms of achievement and/ or progression towards them) should be written into any recovery intervention.

Recommendation 3: Recovery colleges should offer signposting and progression routes to other education and employment focused interventions e.g. volunteering, individual placement support, further education colleges and higher education.

Recommendation 4: All recovery colleges should publish annual performance/impact data, including students' education and employment outcomes.

Recommendation 5: There should be a national evaluation of the recovery college model, which should include an examination of the impact being made on education and employment outcomes.

Appendix

This appendix sets out the key features of some of the most established recovery colleges. Central and North West London, Nottingham and South London and St Georges' all offer courses relating to progression to education and employment but to varying levels of extent.

Table 4. Central and North West London Recovery College [69] [70]

Date opened	January 2012
Mission statement	The primary purpose of the Recovery and Wellbeing College is that of a study and training facility, delivered via a 'hub and spoke' model. The College endeavours to inspire all students to live well and make the most of their skills and talents. It provides a range of educational courses/workshops and resources for people who use or have used services, their supporters (family, friends and carers) and staff.
Geography of provision	6 London boroughs- Brent, Hillingdon, Kensington and Chelsea, Westminster, Harrow and Surrey.
Annual report	2013/14
Commissioning body	Westminster Primary Care Trust and Trustwide
How many students enrolled	1712
User profile (age, sex, ethnicity, disability etc.)	Average age range- 35- 54 years Female students- 979, male students-733 34%- White British 89%- heterosexual 45%- Christian 37%- with a mental health problem, 22% did not disclose, 7%- physical or mobility difficulties.
Staff mix	Recovery Trainers who are employed to work contracted weekly hours, Associate Peer Recovery Trainers who work as and when required to develop and deliver specific courses, Spoke Associate Mental Health Practitioner Recovery, Trainers who are staff employees of CNWL or partner orgs and Volunteer Peer Recovery Trainers.
Training required	Train the trainer 3 day course.

69 Central and North West London NHS Foundation Trust, 'Prospectus Spring/ Summer term', January 2015, available from: http://www.cnwl.nhs.uk/wp-content/uploads/CNWL_RecoveryCollege_Prospectus_2015.pdf.

70 Central and North West London NHS Foundation Trust, 'CNWL Recovery College Annual Report April 2013 - March 2014', April 2013.

How many courses offered?	60
What are the course themes?	Understanding health difficulties and treatment Rebuilding your life Developing knowledge and skills Getting involved.
How many are delivered that relate to employment?	5
What are they?	Making friends with computers and getting online Social media explained How to organise and chair meetings Surviving and thriving at work Introduction to employment courses Employment: Recovery in action Making it work at work To tell or not to tell – what to say to your employer How to apply coaching skills Citizenship and co-production.
DNA rate	39%- across all courses
Independent quality assessment of courses	2 courses have been accredited with the CPD Standards Office. This show that a course has been independently assessed and found to have met a standard of excellence for educational quality.
Has an evaluation been conducted of outcomes relating to employment?	Pre-post-test analysis. Number who reported significant increase in contacts in: Employment: 8 out of 20. Education: 11 out of 20. Volunteering: 11 out of 20.
Partners	Advocacy Project Brent Mind Horizon University of Westminster Brunel University College of North West London

Table 5. Nottingham Recovery College [71]

Date opened	May 2011
Mission statement	They offer a wide range of recovery focused educational courses and resources aimed at supporting people in recognising and making the most of their talents and resources, through self-management, to deal with the mental health challenges they experience and to achieve the things they want to in life.
Geography of provision	Nottinghamshire
Annual report	No
Commissioning body	Unknown
How many students enrolled	600
User profile	Unknown
Staff mix	Professional/ peer trainer mix
Training required	City and Guilds 7300 Train the Trainer and own Trust in house 5 day Advanced Teaching Skills
How many courses offered?	53
What are the course themes?	Understanding Experience of Mental Health Issues, Treatment and Options Building your Life Developing Life skills Physical Health and Wellbeing Getting Involved
How many are delivered that relate to employment?	9
What are they?	CV Writing – filling the gaps Disclosure at Work Preparing to work- in partnership with Central College Resilience at work Returning to learn –in partnership with WEA Thinking of university –in partnership with Nottingham Trent University Thinking of volunteering Work Support Can Do Maths – in partnership with Central College Word Power – in partnership with WEA

71 Nottinghamshire Healthcare NHS Trust, 'Nottingham Recovery College: Spring term prospectus', January 2015, available from: http://www.nottinghamshirehealthcare.nhs.uk/our-services/local-services/adult-mental-health-services/nottingham-recovery-college/

DNA rate	Unknown
Independent quality assessment of courses	Unknown
Has an evaluation been conducted of outcomes relating to employment?	No
Are there any partners?	Central College Nottingham Workers Education Association Rethink Mental Illness University of Nottingham Nottingham Trent University Jobcentre Plus Department for Work and Pensions Nottingham Community and Voluntary Service Voluntary Action Broxtowe

Table 6. South West London and St George's Recovery College [72] [73]

Date opened	September 2010.
Mission statement	The recovery college uses a recovery based approach to help people recognise and develop their personal resourcefulness in order to become experts in their own self-care, make informed choices about the assistance they need to do this, and do the things they want to do in life.
Geography of provision	Springfield, Merton, Sutton, Kingston and Richmond.
Annual report	2011/12
Commissioning body	Clinical commissioning group.
How many students enrolled	1057
User profile (age, sex, ethnicity, disability etc.)	Average age = 42.7 56% female, 44% male 69% are White British 44% have a diagnosis of schizophrenia, 17% diagnosis of depression, 13% bi-polar affective disorder.
Staff mix	4 professionals: 4 peer trainers.
Training required	Train the trainer 2 day course.
How many courses offered?	51
What are the course themes?	: Understanding mental health problems and their treatment. : Rebuilding your life – the road to recovery. : Developing knowledge and life skills. : Educational courses. : Getting involved with the Recovery College.

72 M Rinaldi, M Marland and S Wybourn, 'Annual Report 2011 – 2012', South West London and St George's Mental Health Trust, August 2012.

73 South West London and St George's Mental Health Trust, 'Annual Report 2011 – 2012 South West London Recovery College', 2011.

How many are delivered that relate to employment?	2
What are they?	: Easy Internet for Absolute Beginners. : Return to Work or Study.
DNA rate	38%
Independent quality assessment of courses	Unknown.
Has an evaluation been conducted of outcomes relating to employment?	No
Partners	: Richmond Housing Partnership : Kingston University