June 2016

Yorkshire and Humber Involvement Network

Recovery College CQUIN Bulletin 1

At the first meeting of the Recovery College CQUIN group on the 27th April we started off by looking at the CQUIN guidance to make sure everyone was aware of the content. The CQUIN guidance can be found in full on page 9. We also spoke about the ImROC briefing paper and there is some information about this on pages 2 and 3.

We then went through a short presentation with some ideas from an existing recovery college about the aims, the language used, and looking at outcomes for different stakeholders. This can be found on pages 4 and 5.

We then did some group work so that everyone could think about what outcomes they would like to achieve through doing this work. We looked at service user outcomes, staff outcomes and outcomes for services. This work can be found on pages 6 and 7. We then looked at how we might go about achieving those outcomes in particular around how to make a start, how to evidence co production, and how to measure the impact of the recovery college. This is on page 8.

We finished off the meeting by identifying services to present at the next meeting and asking for volunteers from 2 services to help us lead on this CQUIN, as well as suggestions for future agenda items.

Contents

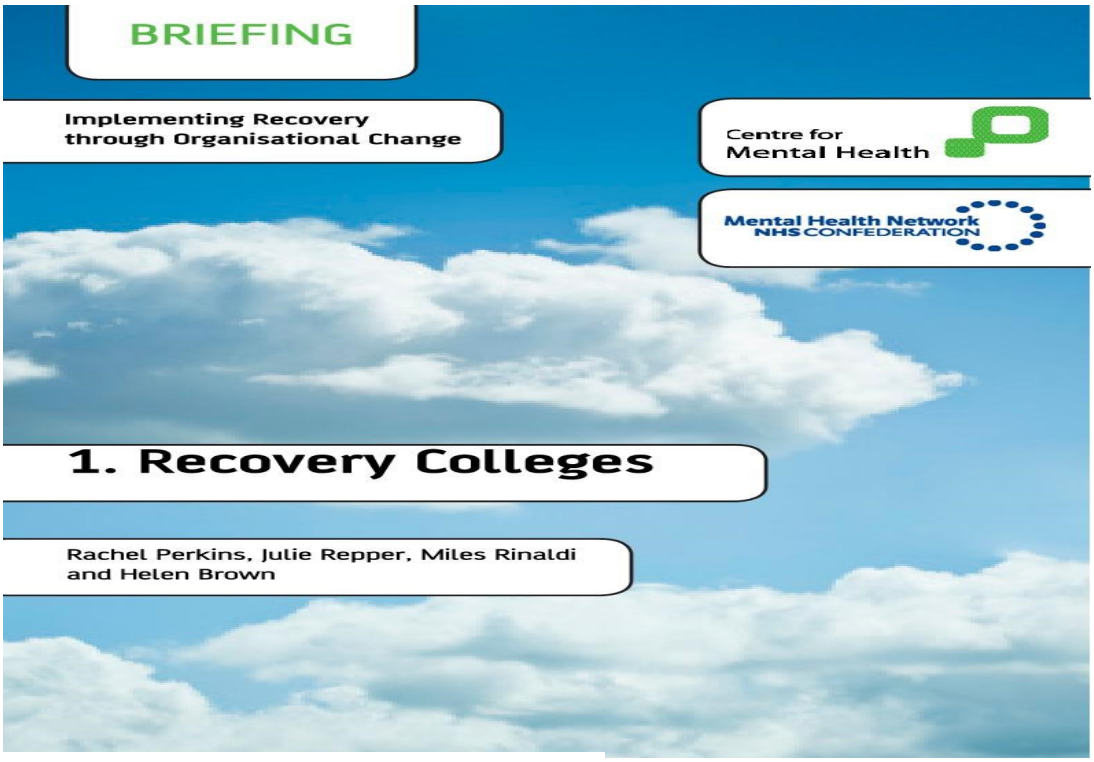
Recovery College CQUIN Agenda

27th April 2016 14.00 – 16.00

1. Welcome and Introductions
2. **Presentation** –CQUIN guidance
3. **Presentation** – Ideas from an existing Recovery College
4. **Group work** – Thinking about Outcomes

5. **Group work** – 6 Thinking Hats – how to achieve our outcomes creatively
6. **Next meeting** – agenda, presentation, lead services

Next meeting – 5th July 2-4



Developing a College and its curriculum

Recovery Colleges are co-produced in local partnerships. The provision of a range of different courses, seminars and workshops allow them to cater for people with diverse needs and preferences. Some people may want to dip in to specific courses, others may wish to construct for themselves a more comprehensive programme. Some people may 'put their toe in the water' with a single session that interests them and then move on to longer courses. The range of courses is determined by those who wish to attend them.

Most Colleges start by bringing together groups of peers and staff to develop an initial prospectus that is then augmented according to the suggestions and requests of students and trainers. Experience suggests that these cluster around five areas:

Understanding mental health issues and treatment options

Some of these courses are single sessions providing an introduction to specific challenges like psychosis, depression, self-harm, substance misuse, dementia and eating disorders. Some provide a more general introduction to the range of mental health difficulties, while others introduce people to the range of treatment options available, for example the range of different sorts of psychological therapies and medication.

Rebuilding life with mental health challenges

These courses range from one day introductions to recovery to longer courses that enable people to develop their own recovery plans and tell their own story. A range of self-management programmes for specific mental health conditions are offered (for example, living with bipolar disorder, coping with depression and anxiety management) as well as courses that help people to look after their physical health care and wellbeing (healthy eating, diet, exercise etc.). Other courses that address particular challenges can be added, such as 'getting a good night's sleep', 'anger management', 'becoming more assertive', 'coping with stress' and 'problem-solving'. Some of the most popular courses include 'life coaching and goal setting for recovery', 'mindfulness', 'pursuing your dreams and ambitions' and 'spirituality and mental health'.

Developing life skills

These courses tend to fall broadly into two areas. First, there are courses that assist people to rebuild their lives outside services, such as: 'managing a budget', 'managing your tenancy', 'looking after your personal safety', 'getting e-connected' and 'returning to work or study'. Second, there are courses that focus on getting the most out of services: for example, 'getting the best from your ward round or care review', 'understanding the Mental Health Act and mental health review tribunals' or 'making a complaint'.

Capacity building among the peer workforce

Recovery Colleges provide courses that drive changes across the service by training peer support workers and peer trainers and providing courses that enable people with lived experience to participate in staff selection and training or sit on committees. The skills and confidence that people gain in these courses are useful not only within services, but are also transferrable to opportunities and employment outside services.

Family and friends

Some courses specifically focus on the challenges faced by people who provide care and support for family members and friends with mental health conditions. These are often attended by the individual and their relatives and assist the whole family to live with the challenges they face. This opportunity for families to learn together has proved particularly popular.

All Colleges produce an attractive prospectus for potential students detailing the courses provided. While staff may inform the people they serve about the College and help them to explore the possibilities there, people are not 'referred'. Individual students enrol and register on the courses that interest them. The Colleges in Nottingham and South West London have grown rapidly, driven by popular demand and it has been difficult to keep pace with demand for courses. In terms of staffing:

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

The evidence base

A core component of Recovery Colleges is helping people to become experts in their own self-care. There is now a considerable body of evidence demonstrating the effectiveness of supported self-management education in health conditions of all types (Rinaldi, 2002; Foster *et al*., 2007; Cook *et al*., 2011). An educational approach which brings together the expertise of professional and lived experience also lies at heart of the 'expert patient programmes' that have proved so useful in relation to a range of long term health conditions (Department of Health, 2001; 2006; Lawn *et al*., 2007). Supporting self-management is now defined by National Institute for health and clinical excellence (NICE) as a key quality standard of adult mental health services, as part of the service user experience guidance (2011).

A wealth of evidence demonstrates the effectiveness of peer support within mental health services (Repper & Carter, 2011) and Recovery Colleges offer peer support from both peer trainers and fellow students.

Recovery Colleges are still in their infancy in this country so the evaluative evidence is limited. However, they have certainly proved very popular among those who use them:

"I wouldn't be here if it wasn't for the College."

"What a positive and helpful approach. This type of course should have started years ago."

"Extremely informative... it has given me further insight into myself and my thinking."

"I can study in a safe place so I don't have to worry if it goes pear-shaped if I get unwell – I can be safe learning."

"It's like the sun coming out to go into the Recovery College... it's a wonderful proclamation of service users (and carers) being of value."

Prior to the establishment of the South West London Recovery College, a pilot study was conducted comprising four recovery courses co-delivered by mental health practitioners and peer trainers (Rinaldi, Wybourn & Clenahan, in press). On average, students had been using mental health services for six years and 45% had a diagnosis of psychosis. Students were enthusiastic about the courses, with an 18 month follow-up showing:

- the majority (68%) felt more hopeful for the future than they had at the start of their course, most (81%) had developed their own plan for managing their problems and staying well; and 70% had become mainstream students, gained employment or become a volunteer;
- compared with those who did not attend courses, those who attended more than 70% of their scheduled sessions (67% of those who started) showed a significant reduction in use of community mental health services.

The comments made by students at Nottingham and South West London Colleges reinforce these findings:

"I have moved further in my recovery in one term here than in the past two years in the team."

"I've halved my medication and learned lots of different ways to manage my anxiety."

"I can't believe what you have done for my son. I used to have to push him out of the door and he would cover his face. Now he goes out with his head held high."

A survey of community mental health team care co-ordinators conducted one year after the establishment of the South West London Recovery College (Rinaldi & Suleman, 2012) showed that the majority (66%) had people on their caseload who had attended the College and they considered that people had benefited greatly from their attendance. In comparison with those who had no-one on their caseload who had attended the College, care co-ordinators who supported people who had used the College placed a higher value on self-management, were more comfortable about supporting them in these endeavours, and had higher expectations for those whom they served. Their comments included:

"I have a strong belief that service users have inner strengths, skills and resources and, with the right support ,such as courses at the Recovery College, can become experts in their own health and wellbeing and rebuild their lives."

"Self-management is an integral part of my own approach which aims to foster independence, increased self-reliance, and the service user's sense of responsibility for their own life outcomes."

The transformative power of the Recovery College

The power of Recovery Colleges is two-fold. First, they assist the individuals whom they serve in their personal and collective journeys of recovery. Second, they assist organisations and services to become more recovery-focused. The creation of recovery-focused services requires a major transformation in purpose and relationships: a focus on rebuilding lives rather than reducing symptoms alone and a partnership between equals, rather than 'experts' and 'patients'.

Recovery Colleges embody and drive these transformations 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

Recovery Colleges enable people to become experts in their own self-care and develop skills and confidence to manage their own recovery journey.

2. They explicitly recognise the expertise of mental health professionals and the expertise of lived experience in a process of 'co-production'

A Recovery College is run by both peer trainers and mental health practitioner trainers. All courses are co-produced, co-delivered and co-received by staff, people with mental health problems and the people who are close to them.

3. They break down the destructive barriers between 'them' and 'us' that perpetuate stigma and exclusion

Co-produced, co-delivered courses enable students to see what people with mental health problems can achieve. Trainers are both people with lived experience and mental health practitioners (who may themselves have lived experience of subjects in which they provide training) and they are employed on equal terms. Barriers between 'them' and 'us' are not only broken down in the provision of courses, they are also broken down within the student group. People with lived experience and those who provide their support (both informal carers and mental health practitioners) learn together and from each other. The transformation from 'service user' to 'student' affords a positive identity beyond that of 'mental patient'.

4. They provide peer support

In Recovery Colleges the peer support offered by peer trainers and fellow students enables people to feel less alone, offers images of hope and possibility and allows people to learn from others who have faced similar challenges and use their lived experience to help others.

5. Group learning and mutual support replaces the disabling isolation engendered by a sole reliance on individual work

Recovery Colleges create a network of social opportunities among peers and the general community which can reduce the social isolation that so many people experience. Like any students, people attending Recovery College courses often form relationships that extend beyond the classroom.

6. They afford choice, control and self-determination

Students are not passive recipients of the 'prescriptions' of experts. Within a Recovery College there are no prescriptions: students select the courses that interest them from a prospectus, do their own research in a library, and attend courses that enable them to take control and pursue what is important to them.

7. They promote participation in the local community

A Recovery College achieves this in three ways. First, people from local organisations can be involved in providing courses. Second, individuals can attend courses that assist them to develop the knowledge and skills necessary to return to work, study, and participate in the community. Third, people with a diagnosis of a mental health condition study alongside their relatives, friends and neighbours.

From margins to mainstream

Many services are in the process of developing Recovery Colleges, however, they remain 'pilot' services. Their full transformative power cannot be fully realised until they move from being a novel, marginal addition to being a central component of recovery-focused services.

For individuals, the research literature demonstrates the importance of ensuring that self-management education is fully integrated into healthcare systems and that learning is reinforced by all professionals with whom the person has contact (Coulter, 2011; Protheroe, Rogers & Kennedy, 2008; Pulvirenti, McMillan & Lawn, 2011). Similarly, if people are to take control over their lives and pursue their aspirations it is important that the confidence, skills and insights they gain from the Recovery College are not undermined by experiences with other parts of the mental health service.

For services and organisations, the Recovery College must become a core driver for whole system change. This can be achieved in three ways. First, they are able to model different relationships between people using services and mental health practitioners. Second, they can identify and prepare people with lived experience for employment as peer workers across the service. And third, they may replace some elements of existing services. These elements can make a Recovery College a high impact development with a major 'domino effect' across a mental health service over time.

Colleges cannot, of course, replace all specialist assessment and treatment or non-specialist outreach support. But mental health services try to provide a great deal more than this in the form of information, advice on self-management and support in day-to-day life for both individuals and their families – all delivered, almost exclusively, on an individual basis. The opportunity to reduce costs and provide services in the form of co-produced seminars and courses that decrease isolation and increase peer support, while at the same time offering a broad range of professional expertise, therefore has the potential to deliver a 'win-win' situation – better services at lower cost.

BRIEFING Recovery Colleges Centre for Mental Health NHS Confederation Mental Health Network

Recovery College CQUIN Group 2016/17

MH2 Recovery Colleges for Medium and Low Secure Patients

Examples of a Recovery College

Recovery College Aims…

- **Break 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.**

- **The college brings together two sets of expertise – professional and experience – in a non-stigmatising college environment with the same systems as other educational establishments.**

- **All of the courses provided at the college are designed to contribute towards wellbeing and recovery. People who share experiences of mental health or physical health challenges teach on the courses with the intention of inspiring hope and embodying principles of recovery**

"I've moved on in my recovery through taking part in the Recovery College – more than in the whole time I have been here"

"It's really taught me a lot, about myself, my medication, my anxiety"

From Hospital	To Recovery College
Patient or client	Student:
Therapist	Tutor
Referal	Registration
Professionally facilitated groups	Education seminars, workshops and courses
Prescription:"This is the treatment you need"	Choice: "Which of these courses interest you?"
Discharge	Graduation

ImROC key organisational challenges

1. Changing the nature of day-to-day interactions and the quality of user experience
2. Delivering comprehensive, user-led education and training programmes to increase staff awareness
3. Establishing a '*Recovery Education Centre*' to drive the training programmes forward
4. Ensuring organisational commitment (policies and procedures) changing the 'culture'
5. Increasing 'personalisation' and choice
6. Transforming the workforce ('peer support professionals')
7. Changing the way we approach risk assessment and management
8. Redefining user involvement as '*partnerships-between-experts*'
9. Supporting staff in their recovery journeys
10. Increasing opportunities for building '*a life beyond illness*' .

"My sister has come on leaps and bounds in terms of her insight, through learning about her illness"

"I have always hated school and lessons, but this is different because it's actually about things that interest me"

Possible organisational outcome

- Based on Recovery Education Centre in Arizona

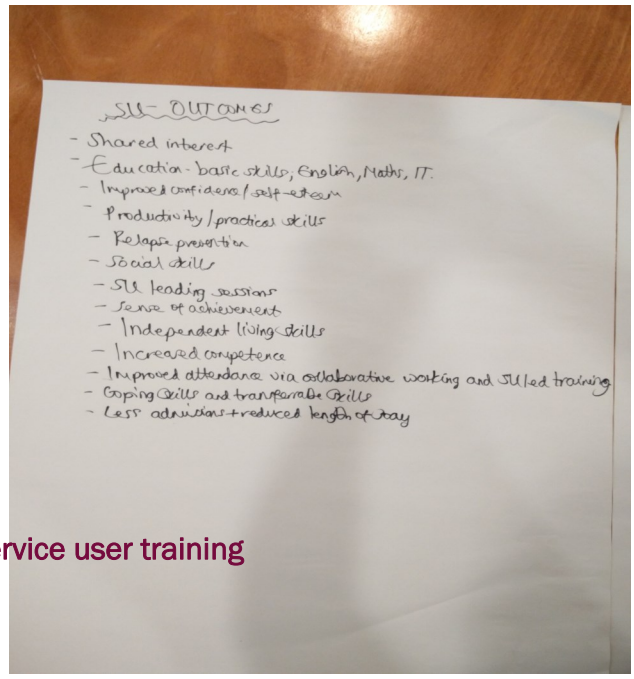
"We decided to use education as the model for promoting Recovery, rather than develop more traditional treatment alternatives. We did this because we wanted our centre to be about reinforcing and developing people's strengths rather than adding to the attention on what is wrong with them. The guiding 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" (Ashcroft, 2000)

Stakeholders

- Co-production
- Experts working together in a process of shared decision making.
- Model in which experts by profession work collaboratively with experts by experience .
- Co-delivery
- Model in which each course is delivered by an expert by experience and an expert by profession
- Varying levels of involvement

"I love being part of the teaching side, showing my skills and helping others"

Group work—What Outcomes do we want to achieve? For service users, staff and services



Recovery College

Service user outcomes

Shared interest

Education – basic skills, maths, English, IT

Improved confidence, self esteem

Productivity / practical skills

Relapse prevention

Social skills

Service user leading sessions

Sense of achievement

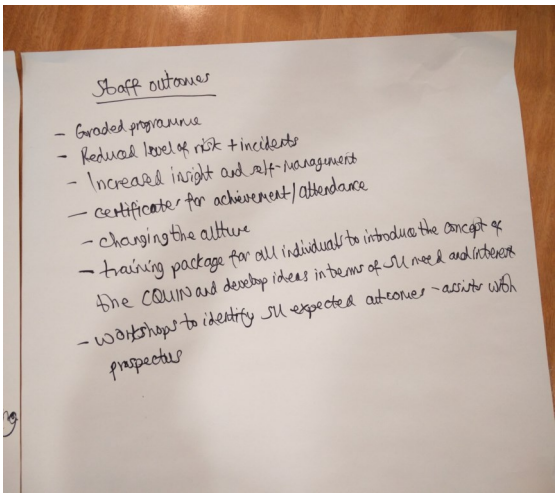
Independent living skills

Increased competence

Increased attendance via collaborative working and service user training

Coping skills and transferable skills

Less admissions and reduced length of stay



Staff outcomes

Graded programme

Reduced level of risks and incidents

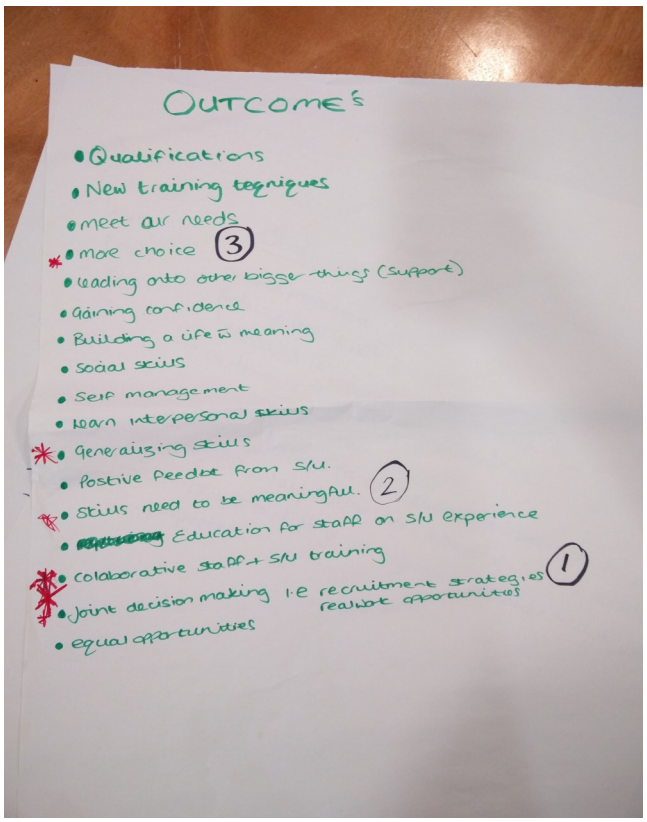
Increased insight and self management

Certificate of achievement / attendance

Changing the culture

Training package for all individuals to introduce the concept of the CQUIN and develop ideas of service user need and interest

Workshops to identify service user expected outcomes – assisted with prospectus



Qualifications

New training techniques

Meet our needs

More choice

Leading on to bigger things (support)

Gaining confidence

Building a life with meaning

Social skills

Self management

Learn interpersonal skills

Generalising skills

Positive feedback from service user

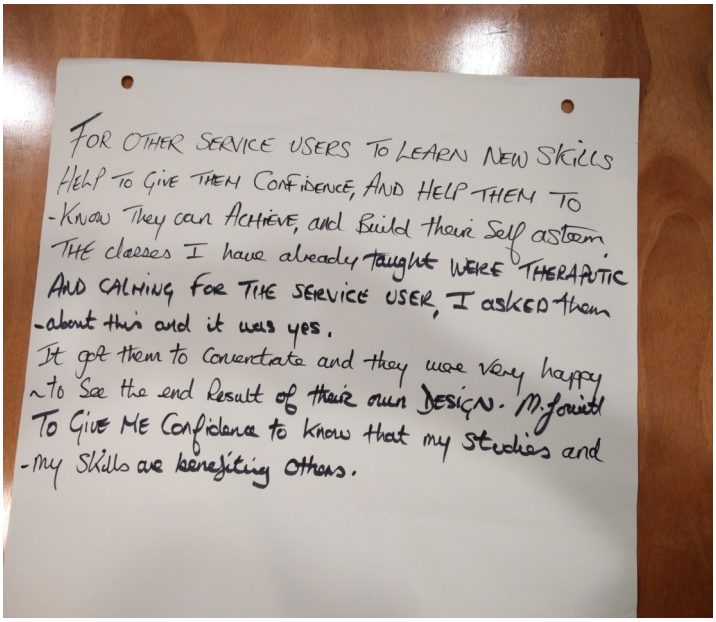
Skills need to be meaningful

Education for staff on service user experience

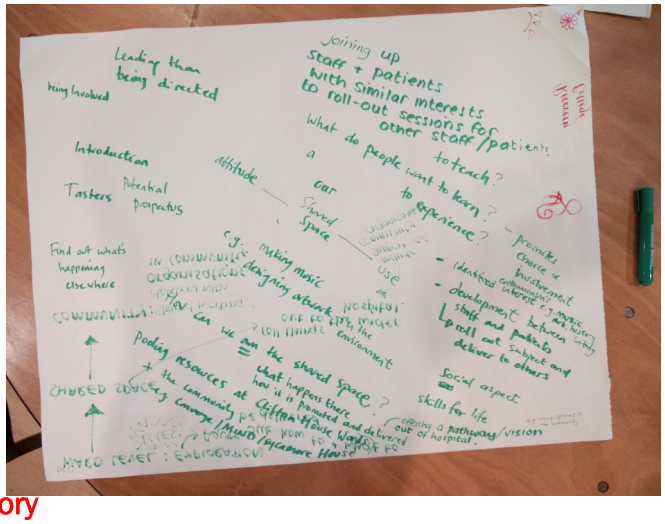
Collaborative staff and service user training

Joint decision making like recruitment strategies and real work opportunities

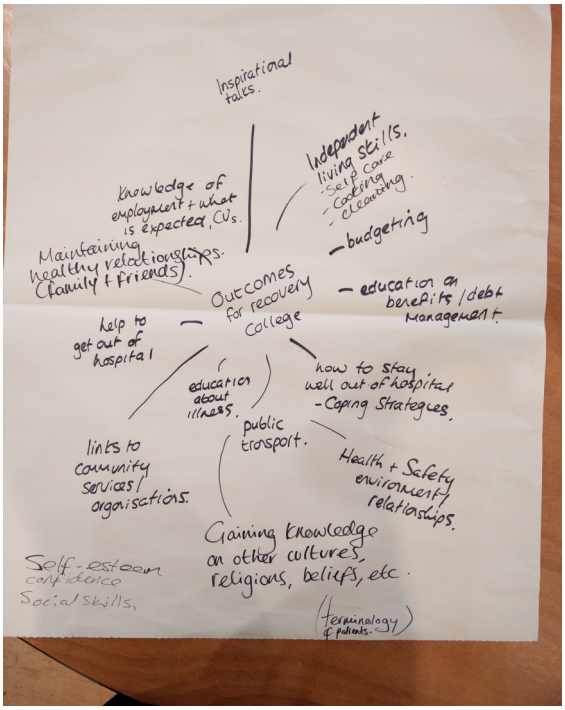
Equal opportunities



For other service users to learn new skills to help give them confidence and help them to know they can achieve and build their self esteem. The classes I have already taught are therapeutic and calming for the service user. I asked them about this and they said yes. It got them to concentrate and they were very happy to see the end result of their own design. To give me confidence my studies and my skills are benefitting others



Leading them being directed. Being involved.
Introduction. Potential prospectus. Tasters
Find out what's happening elsewhere
Joining up staff and service users with similar interests to roll out sessions for other staff / patients
To teach? What do other people want to learn?
To experience? Promotes choice and involvement
Identified enthusiasms and interests eg. Music, art, history
Development between staff and patients – roll out subject and deliver to others. Social aspect
Skills for life. Attitude – out shared space – use
Eg. Designing artwork, making music in the environment. How can we <u>own</u> the shared space
What happens there? – offering pathway out of hospital – a vision. How is it promoted and delivered
Pooling skills and resources at Clifton House – wards and community – e.g., converge, MIND, sycamore house. Ward level – Roles – Exploration – figure out how to and what to be delivered
Shared space – roll things out to wider hospital – include support of community organisations
Community – shared working / delivery with organisations in the community



Inspirational roles
Independent living skills / self care, cooking, cleaning
Budgeting
Education on benefits and debts management
How to stay well out of hospital, coping strategies
Health and safety – environment, relationships
Public transport
Education about illness
Gaining knowledge on other cultures, religious beliefs
Links to community services / organisations
Self esteem, confidence, social skills
Help to get out of hospital
Maintaining healthy relationships (family and friends)

How to make a start

Overall we are doing it under a different title

Stopping stigma. Get a working group to plan

Include service users and staff

Deliver training about the CQUIN and what it includes – what is a recovery college for us? Ask service users what their needs are. Find out service user and staff skills and enthusiasm to capitalise on

Changing culture doing things in different ways

Changing language. People moving on. Existing commitments. Lack of enthusiasm / motivation

Confidence. Co-production and co-delivery

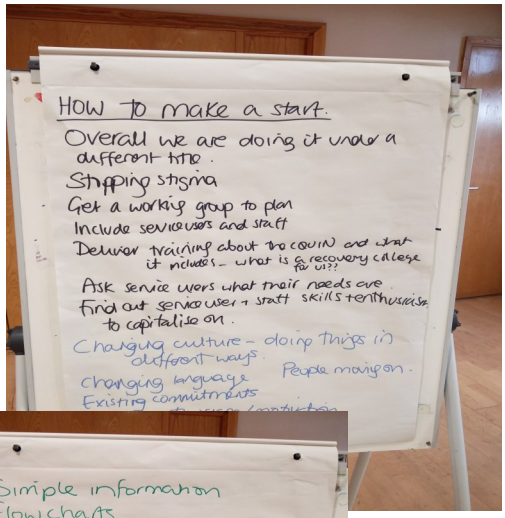
Simple information. Flow charts. Friendly and clear information. Send out basic information leaflet, questionnaires to service users and staff (same)

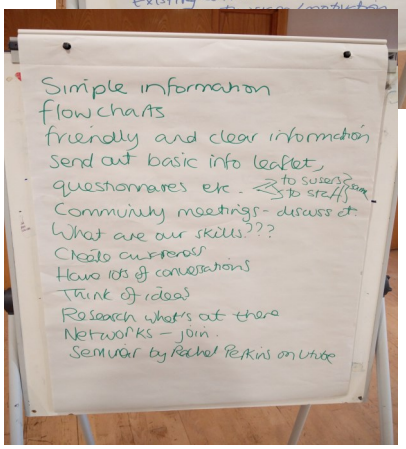
Discuss at community meetings. What are our skills?

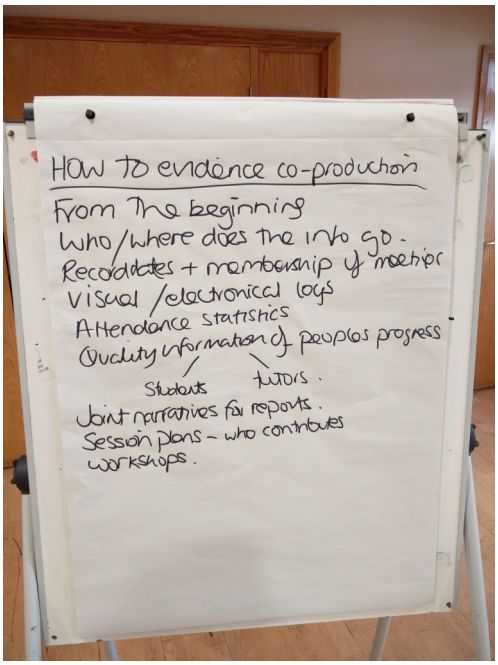
Create awareness. Have lots of conversations

Think of ideas. Research ideas. Join networks

Seminar by Rachel Perkins on YouTube







How to evidence co-production

From the beginning

Who and where does the information go

Record dates and membership of meetings

Visual / electronic logs

Attendance statistics

Quality of information on peoples progress – students and tutors

Joint narratives for reports

Session plans – who contributes

Workshops

How shall we measure the impact of the recovery college

Capture baseline at start. What groups do we have now?

What is attendance like? How does it change?

Qualitative reports – development plans

Capture individual achievement

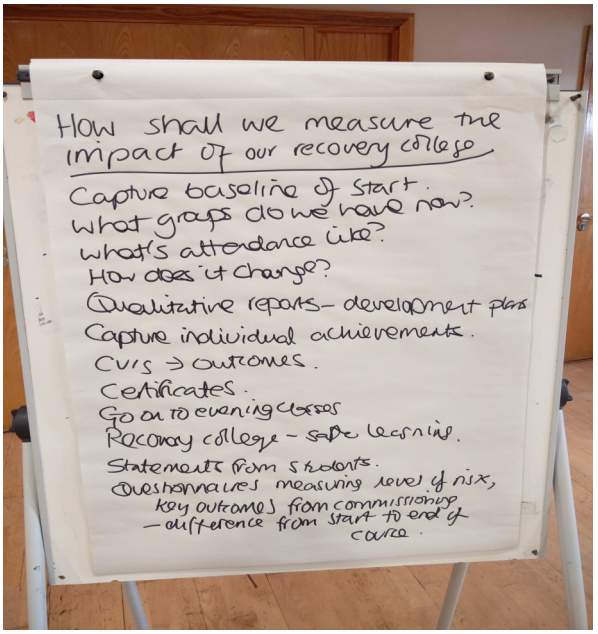
CVs – outcomes. Certificates

Go on evening classes

Recovery college – safer learning

Statements from students

Questionnaires measuring level of risk, key outcomes from commissioning – difference from start to end of course



MH2 Recovery Colleges for Medium and Low Secure Patients

Scheme Name	MH2 Recovery Colleges for Medium and Low Secure Patients
Eligible Providers	All providers of medium and low secure mental health services
Duration	April 2016 to March 2018.
Scheme Payment (% of CQUIN-applicable contract value available for this scheme)	CQUIN payment proportion [Locally Determined] Target Value: 1% CQUIN %: 2.5%

Scheme Description

The establishment of co-developed and co-delivered programmes of education and training to complement other treatment approaches in adult secure services. This approach supports transformation and is central to driving recovery focused change across these services.

Recovery Colleges deliver peer-led education & training programmes within mental health services. Courses are co-devised and co-delivered by people with lived experience of mental illness and by mental health professionals, and are based on recovery principles.

In mental health the term recovery is used to describe the personal lived experiences and journeys of people as they work towards living a meaningful and satisfying life. Recovery does not only equate to cure or to *clinical* recovery, which is defined by the absence of symptoms. Recovery principles focus on the whole person in the context of their life, considering what makes that person thrive. Positive relationships, a sense of achievement and control over one's life, feeling valued, and having hope for the future are some of the factors we know contribute to personal wellbeing.

Most secure services will have access to an appropriate base from which the college will run. Staffing costs are incurred as re-profiling roles and job plans of individuals displaces other activity. Service user involvement is crucial but voluntary. There are some costs associated with printing and publicity.

It is expected that after one year of this CQUIN, a needs analysis and patient engagement programme would have produced a prospectus, and the means to deliver the programme identified, and by quarter four course will have commenced. In year two, the college will have begun to establish itself and begin delivering courses and the expected outcomes in terms of patient engagement and satisfaction.

Measures & Payment Triggers

Year 1 (2016/17)

Trigger 1:

- Evidence of engagement of staff and patients in developing the Recovery College.
- Minutes of planning groups
- Course Prospectus
- Outcome Measures
- Agree standardise measures of intervention to allow evaluation of impact.
- Agree groups of patients to be targeted for courses by Q4, with exclusions justified.
- Q1: agree plan of milestones for process measures for rest of year.

Trigger 2:

- Proportion of target patient group enrolled and participating in courses in Q4.

Note that the purpose of linking payment to enrolment and participation is to ensure courses are designed in such a way that patients find them valuable; that aim would of course be subverted were engagement with patients to encourage participation coercive.

Year Two (2017/18) scheme to be developed in course of 2016, but to include:

1. Evidence of implementation of Recovery College strategy and description of evaluation and assessment tools:
   - Quarterly Report
   - Course Prospectus
   - % of patients participating in courses
2. Development Plan to Improve:
   % of patients who understand their condition and how to manage it
   % of patients reporting positive outcome measures

Definitions

Patient eligibility:

- Excluded, patients expected to stay less than three months
- Other restrictions of scope (if any) as agreed at contract between provider

In both cases, groups of patients who are excluded from the scope of the CQUIN scheme are not being judged ineligible for the Recovery College *per se*, or unable to benefit. Eligibility for the scheme is rather determined on the basis of prioritisation:

- nationally priority is given to patients with expected length of stay > 3 months;
- locally priority may be given to particular groups of patients according to the commissioner's and provider's judgment of the best value roll-out of the Recovery College service.

Partial achievement rules

Year 1 payment: 80% process (Trigger 1) and 20% outcome (Trigger 2)

Payment trigger 2: % targeted population enrolled and participating in courses in Q4 determines payment: Enrolment percentage plus one ninth i.e. 100% payment at 90%+ enrolment and participation, 50% payment at 45% enrolment and participation. Proportionately lower payment for lower achievement.

"Participation" is to be defined locally and reasonably – the intention is to count those patients who are likely to be deriving benefit from the College.

In Year Payment Phasing & Profiling

Year 1
Q1 – 20% (Trigger 1 – Process)
Q2 – 20% (Trigger 1 – Process)
Q3 – 20% (Trigger 1 – Process)
Q4 – 20% (Trigger 1 – Process) and 20% (Trigger 2 – Outcome)

Rationale for inclusion

The Government's Mental Health Strategy 'No Health without Mental Health' sets an objective for more people with mental health problems to achieve recovery. This builds upon the objectives in the Health and Social Care Act to allow service users to be partners in their care, to have clear involvement in planning at both individual and service level and have genuine treatment choices made available to them. Embedding a recovery-based approach will play a central role in achieving positive patient reported outcomes and improving patient experience. This in turn leads to improved clinical outcomes, reduced lengths of stay and fewer readmissions.

Data Sources, Frequency and responsibility for collection and reporting

Reports of achievement of payment triggers should be made available to commissioners on a standard report form.

Baseline period/date & Value	N/A
Final indicator period/date (on which payment is based)	As above.
Final indicator reporting date	Month 12 Contract Flex reporting date as per contract
CQUIN Exit Route *How will the change including any performance requirements be sustained once the CQUIN indicator has been retired?*	The start-up costs of a Recovery College relate to the initial scoping, identification of need, developing courses and securing an appropriate base to operate from. A temporary financial incentive will allow providers to prioritise the development of a recovery college which will yield longer term benefits. Once established, it is expected that the running of Recovery College should be met within the general operating costs of a service.

Supporting Guidance and References

"Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services, NICE clinical guideline 136" National Institute for Health and Clinical Excellence (2011)
www.nice.org.uk/cg136

'No Health Without Mental Health' DH (2011)
'Recovery Colleges briefing', Centre for Mental Health (2012)

This scheme is relevant to all adult medium and low secure providers nationally. Benefits from this CQUIN scheme are service-user focused and include:

- Improved Patient Experience
- Improvement in recovery related outcomes
- Improvement in self-awareness and self-management
- Reduced length of stay
- Fewer readmissions

Secure services represent high cost low volume services, with lengths of stay running into many years and an annual bed price of between £150,000 and £200,000. Costs of establishing and running a Recovery College centre are estimated to be modest in relation to the outcome gains expected.

Recovery College

CQUIN Group

Tuesday 5th July 2016

Tuesday 1st November 2016

Sandal Rugby Club Wakefield

2 – 4 pm - Refreshments Provided

Role Description for attending Yorkshire and Humber Network meetings:

Represent your service and share experiences and ideas

Celebrate achievements and share learning

Find out what is happening in other services

Give your perspective

Meet staff and service users from other services

Take back and share what you have learnt with people in your service

Recovery
The Recovery College