Setting up a Recovery College: Exploring the experiences of mental health service-users, staff, carers and volunteers.

Ali, I., Benkwitz, A., & McDonald, P.

Newman University, Birmingham, UK

Abstract

Following the first recovery college being established in 2009, there has been considerable growth in the number of colleges internationally as they have become established features of service transformations. This is the first study that has holistically explored setting up a recovery college from the combined perspectives of service-users, staff, carers and volunteers involved in the development process. An interpretative phenomenological analysis was undertaken following 25 semi-structured interviews. Results included three key themes of 'Challenges in the early stages of development'; 'Having a shared understanding of recovery'; and the 'Conceptualisation of Recovery Colleges'. This study demonstrated that, as well as future groups seeking to set up a recovery college having clear conceptualisations of personal recovery and the underpinning approach of their recovery college, they should actively manage the level of integration between the college and its host organisation, with open conversations about the power imbalances and roles of service-users, staff, carers and volunteers involved. Those planning to develop a college should also be mindful that although there will be the early challenges as outlined in this study, there are broader benefits for both individuals and the wider organisation via the process of planning and discussions of how to implement co-produced, recovery-oriented practice such as a recovery college.

Keywords

Recovery college; mental health; personal recovery; service-user.

Introduction

Within the United Kingdom (UK), recovery ideologies are now considered a fundamental component within mental health policy by both governmental and mental health professional bodies (Department of Health, 2009; Toney et al., 2018). The UK's policy document 'The Journey to Recovery - The Government's Vision for Mental Health care' (Department of Health, 2001) called for a transformation of the mental health system by announcing policies aimed at transforming mental health services by fostering recovery-oriented principles, leading to a slow but steady increase in the appreciation of recovery in the UK. The discourses relating to mental health, illness and recovery are complex and multifaceted, from which many polarised views exist embedded within clinical, political, and academic philosophies (Read, Adiibokah, and Nyame, 2009). Two broad constructs are at the heart of a rise in tensions, polarised views and a crisis of beliefs across mental health service provisions (Watson, 2012). The first is known as clinical recovery, encompassing a biomedical view rooted in a belief that mental illness is simply another manifestation of physical illness, a condition in

its more serious forms is lifelong, unremitting, degenerative and dependent on medical intervention (Lieberman et al., 2008) usually assessed and judged by 'experts' (Watson, 2012) and legitimised by legislation such as the Mental Health Act 2001. A chemical imbalance is the primary cause of mental illness within this ideology, therefore recovery can be considered synonymous with cure or a restoration of the brain's chemical balance through medication (Lieberman et al., 2008). More recently the clinical recovery perception is challenged by the second construct, commonly referred to as personal recovery (Watson, 2012), supported by a recovery orientated model that advocates a shift from managing symptoms to supporting individuals to come to terms with, and overcome, challenges associated with living with a mental illness, by helping to instil key concepts found to be important in personal recovery (Davidson, 2005). Personal recovery can be seen as a subjective process (Benkwitz et al., 2019) that is not synonymous with cure. Rather, it refers to gaining control over one's life, building resilience allowing for individual strengths and coping skills to develop in order to live a satisfying life (Davidson et al., 2009).

Recovery Colleges

It is difficult to be certain of the number of recovery colleges globally, as there is not a specific over-arching body that can monitor developments. In 2020 it was stated that there were more than 80 recovery colleges operating across at least 22 countries (Theriault et al., 2020), however, an earlier report by ImROC (Implementing Recovery through Organisational Change) in the UK in 2017 listed the names of 85 recovery colleges in the UK alone (Anfossi, 2017). The concept and development of recovery colleges from 2009 onwards stems from both the growing need for mental health service provision to become more recovery-oriented (Toney et al., 2018), combined with the view that many believe the offer of mainstream services is limited in addressing inequalities and supporting those with long-term conditions (Burhouse et al., 2015). The focus, and challenge, of recovery-orientated services is shifting to practice that is built on equal partnership, hope-promoting and facilitating self-determination across the practice and delivery paradigms (Slade et al., 2014). Recovery colleges are said to be attempting to achieve these aims by adopting an educational rather than a clinical or therapeutic approach (Toney et al., 2018), underpinned by an ethos of experience sharing and normalising of mental health difficulties (Perkins and Repper, 2017). People experiencing mental health difficulties, professionals and carers attend as students to a non-prescriptive service where courses are co-designed and co-delivered by people with lived experience and professionals (Perkins et al., 2012). This represents the type of shift in power away from the professionals who would have traditionally had the authority to define and recognise recovery that Anthony (1993) previously called for in recovery-orientated practice. A central component to recovery colleges is the need to use education as a means in helping to break down barriers and stigma associated to mental health

(Shepherd et al., 2014). Another key component is co-production throughout the whole college and its culture, enabling an environment where skills and experiences can be exchanged as well as building on existing capabilities (Hashagen et al. 2011). Perkins et al.'s (2012) original ImROC briefing paper identified 10 common features of recovery colleges, and whilst the development, structure, and delivery does seem to vary to some degree, there appears to remain a commonality of the original core features (King and Meddings, 2019).

Despite the evidence base for recovery colleges being in it's infancy, initial studies have demonstrated a number of benefits to service users, including: helping progression towards goals of increased wellbeing and quality of life (Sommer et al., 2019); a positive reduction in service use (Bourne et al., 2018); and a reduction in self-stigma (Nurser et al., 2017). Furthermore, Crowther et al. (2019) provided an overview of studies that demonstrated the benefits of being involved in a recovery college for staff (including improved morale, job satisfaction and hopefulness about recovery), as well as benefits for the trainers involved in the delivery of sessions (including improved self-esteem, professional growth and being inspired). Meddings et al. (2014) did undertake an action research study that focused specifically on the co-production undertaken during the setting up of a pilot recovery college in the UK, which highlighted how beneficial co-production can be in this context. However, as Theriault et al.'s (2020) review of the recovery college literature demonstrated, there remains a lack of evidence in terms of a holistic study that explores the experiences of service-users, staff, carers and volunteers during the setting up and establishing of a recovery college.

Methodology

The aim of the study was to explore the experiences of individuals involved in the development of a recovery college within a large mental health NHS Trust in the West Midlands, UK. Individual sense making experience is a ‘private phenomenon' and cannot be accessed, except through shared symbolic representation - for example, the development of discourse and language relating to experiences (Smith, Flowers and Larkin, 2009). Therefore, if the broad research question is to explore the experiences that matter (Larkin and Thompson, 2012) to those involved in the establishment of the recovery college (through their discourse and language), then the underpinning philosophy had to reflect this requirement. This study subscribed to a relativist position, which states reality is a social, and therefore, multiple, construction (Lincoln 1990) and social reality is the product of social actors with interpretations, cultural and social meanings, and subjectivities having a bearing on the construction of reality. There are multiple realities, and the researcher presents a specific version of that reality (Sands 2002). When applying an interpretivist paradigm, Crotty (1998) stated no one true interpretation exists, but rather multiple possible interpretations. According to this perspective there

are common themes in the lived experience of the participants and common meanings across the participant sample. There are also personal, individual, unique and subjective experiences and meanings for each of the participants (Smith, Flowers and Larkin, 2009). Interpretivism was chosen as the appropriate epistemology for this study as the source of meaning making came from multiple participants and was used to explore the meanings of the lived experiences of individuals involved in the development of the College.

Interpretative Phenomenological Analysis (IPA) was chosen as a methodological approach, as it is concerned with the exploration of in-depth experiences, and is particularly used for understanding under-examined phenomena or novel phenomena, or that which is difficult to explain (Smith and Osborn, 2003). For this purpose, a lived-experience account of the meaning-made of the phenomena can provide a very rich and detailed understanding of the phenomena from particular perspectives (for example, from the perspective of being a service-user or a carer in mental health services, or perhaps a staff member who also considers themselves to be a carer). Furthermore, this qualitative study is in line with Meddings et al.'s (2015) call for more qualitative and mixed-methods studies to develop the evidence base for recovery colleges in the UK and globally.

In terms of the analysis process, IPA offers comprehensive guidance to help the researcher to work through a number of steps and stages (Smith, Flowers and Larkin, 2009). Having these guidelines on which to base the analysis is beneficial as the structure provides reassurance and the emphasis on flexibility, and the lack of strict prescription is also positive, meaning that there is not a specific requirement to complete the analysis in the ‘right way', but instead to adhere to the general principles underpinning the process. The cyclical, interactive process offers something more dynamic than a linear approach, which means that deep immersion in the data is possible and in fact necessary (Larkin and Thompson, 2012). The aim of IPA is to focus upon people's experiences and to develop an interpretation of their perspective and understanding of a particular phenomenon (Smith, Flowers and Larkin, 2009), in this case the recovery college.

Interviews

Within interpretivist research, semi structured interviews are considered a common approach to data collection (Smith, Flowers and Larkin, 2009). The technique adapts a format that for many is intuitively understood and enables both the interviewer and responder to create a rapport that may inspire and enable a more natural conversational experience to develop (Fontana and Frey, 2000). Therefore, semi-structured interviews were the chosen method for the data collection.

Sampling

Participants for this study were recruited via purposive sampling (Flick, 2013) through the Recovery College Advisory Group (i.e., the group acted as a gatekeeper to advise who might be suitable for an interview, and were able to pass on the lead author's contact details in order to provide further information and potentially plan for them to be involved). In addition, in an effort to reduce 'selection bias', the lead author attended many of the meetings of the group to build rapport/familiarity and share contact details with potential participants who wanted to get in touch or ask questions about the study or their potential involvement, which was voluntary, and there were no payments for giving their time as a participant in the study. Aside from having to be over the age of eighteen, there were no specific inclusion or exclusion criteria relating to gender or other demographic factors. The only inclusion criteria were that they needed to have been involved for a significant period of time as either staff, carers, family members, volunteers or service users in the development of the recovery college. During the (approximately) three years of the development and 'setting-up' of the recovery college there were around 40 individuals involved in the development group, and in terms of recruitment for this study the aim was to try to recruit as many of that group as possible. In total 25 individuals were recruited, of which: four identified as service users; four described themselves as having a dual role as both service user and member of staff; two participants were carers who also had a role within the Trust; two participants were third sector partners and considered themselves volunteers; and the remaining twelve participants identified as staff within the Trust. This ratio of service-users, staff, carers and volunteers recruited as participants was, broadly speaking, representative of the ratios of the actual development group involved in setting up the recovery college.

Ethics and Interview Process

During the early research design phase the research team met with the SureSearch group of service users (suresearch.org.uk) to discuss the study and gain feedback and suggestions from the service users (and carers and Trust governors) prior to seeking ethical approval. Some of the points highlighted were the importance of valuing the (potentially) different experiences of service-users, carers and family members as well as the staff members; and to keep in mind how valuable it is to actively listen to people and their stories. In addition to receiving ethical clearance from the University ethics committee, the study also received full ethical clearance from the NHS Integrated Research Application System (IRAS) (project ID 226545). Subsequently, the researcher liaised with the Trust's Research and Innovation Team in order to establish the expectations of the study 'locally', and then a letter of access was granted for the research to be undertaken. All participants were required to provide written informed consent prior to data collection commencing. The study

did not seek to access any service-user case files or patient notes, as these were not relevant to the research focus. A distress protocol was provided within the participant information sheet in case a participant found any aspect of the process caused them distress, and all interviews were conducted on an NHS site with clinical staff present in the building, although given the nature of the study it was not envisaged that these precautionary steps would be utilised (which was in fact the case). The interviews included a series of open-ended questions about the participants' involvement in the group that set-up the recovery college (for instance, “Can you tell me about how you first became involved in the recovery work within the Trust and what prompted you to get involved?”) and other related aspects of the work the group were involved in (for instance, “Can I ask what your interpretation of the term ‘recovery' is, and where does that understanding come from?”; “Can you tell me about your understanding of the term ‘Co-production'?”), as well as probes and prompts to explore or clarify (for instance, “Why do you think that was the case”; “What do you think informed that decision?”). Interviews were undertaken and audio-recorded by the lead author, and later transcribed verbatim.

Analysis of Data

For this study, IPA guidelines as outlined by Smith, Flowers and Larkin (2009) were adapted and used flexibly, as the generalisability of existing literature on IPA analysis does “not prescribe a single method” for working with the data (Smith, Flowers and Larkin, 2009, p.79). It must also be highlighted that the analysis was in fact a cyclical process, rather than a linear one, as IPA is iterative. It allows the researcher to move back and forth through the descriptive data developing various ways of thinking and making sense from different perspectives gaining content, detail and context (Larking and Thompson, 2012). IPA aims to move the focus from the individual to more a shared understanding and from a descriptive level to more an interpretative one (Smith, Flowers and Larkin, 2009). Each transcript was individually read and reread (Larkin and Thompson, 2012). To enable full immersion in the process and to help with imagining the voice of the participant during subsequent readings, the lead researcher elected to listen to the audio recordings during the reading of the transcripts. Through the analysis, superordinate and subordinate themes were identified, and form the basis of the results and discussion of the study. The lead researcher initially analysed the data case by case, and then began to look for patterns across cases according to conceptual similarities. On a separate sheet of paper, each transcript was reviewed, and any initial themes were listed as they appeared in the transcript. Themes showing common links were then clustered together using the concepts of: abstraction (where themes showing similarities were grouped together); subsumption (where emergent themes became subordinate theme); numeration (frequency in which theme is supported signifies importance); and function (what function it serves), producing a number

of superordinate themes and then into subordinate themes (Smith, Flowers and Larkin, 2009). During this lengthy, iterative process the researcher also employed ‘member checking' (Goldblatt et al., 2011) with some participants, as well as discussing the coherence of the developed superordinate and subordinate themes with the other authors to aid with clarity and communication. It is recognised that all researchers have their own subjectivities and bring experiences and perspectives to the research process, therefore, in an effort to diminish and consider these aspects and reduce what could be considered as ‘analysis bias' the lead author took a number of specific steps. Firstly, a bracketing (Smith, Flowers and Larkin, 2009) process was undertaken by the lead author prior to undertaking the interviews to identify anything that may impact the data collection process and help inform the subsequent analysis. The lead author also kept a research diary that was completed after each interview and used a reflective technique to consider how they were interpreting the data as well as other aspects such as their own body language and tone.

Results

To provide context for the overall study's findings, table 1 provides an overview of the superordinate and subordinate themes identified following the data analysis. However, the findings and discussion here shall focus around the first key superordinate themes of ‘Challenges in the early stages of development'; ‘Having a shared understanding of recovery'; and the ‘Conceptualisation of Recovery Colleges'.

Table 1. Composition Structure of IPA Themes

Superordinate Themes	**Subordinate Themes**
1. Early stages of the Recovery College development	1.1 Involvement 1.2 Early challenges 1.3 Supporting recovery at an organisational level 1.4 Non-cashable cost saving 1.5 Ownership
2. Conceptualisation of Recovery	2.1 Developing an understanding of recovery 2.2 Defining personal recovery
3. Conceptualisation of Recovery College	3.1 Recovery College Model (Clinical/Therapeutic/Educational) 3.2 Organisation's recovery understanding
4. Connecting with others differently	4.1 Co - Production 4.2 Peer Support 4.3 Lived Experience 4.4 Shared Learning Environment / Pedagogy
	4.5 Nonprescriptive learning 4.6 Language to empower
5. Widening horizons	5.1 Reasons for attending 5.2 Identity

6. Sustainability and ambition for the future	6.1 Planning 6.2 Organisation Commitment 6.3 Stakeholders and Partners 6.4 Open to all

Challenges in the early stages of development

Crowther et al. (2019) identified how recovery colleges often develop somewhat separately from their host system, reducing the reach of the college into the host organisation but allowing development of an alternative culture. A key theme for this study was the experiences of service-users, staff, carers and volunteers co-producing the planning of the RC in the 'early days' under the 'umbrella' of the mental health Trust, and there are a number of challenges that may resonate with others in health services who seek to implement recovery-oriented practice. Participants often reflected on the early tensions from the change in culture and practice with the co-produced, recovery-focused planning process, as one service-user involved from the development phase onwards commented:

> "The initial meetings were very much driven by the staff, which probably needed to happen as they wanted to make this movement happen, but when we started to invite more service users to join for the service to become more user led, the pace and structure of the meetings required adjusting and many staff struggled with this" (Participant 18).

These tensions were often exacerbated by the structure and 'red-tape' bureaucracy that hindered the planning process from the beginning:

> "We simply made this happen because it was the right thing to do, and it was definitely in no one's job description. We could have been stopped at any time; it was very much a staff driven rather than organisational initiative. If you want to develop something new you can go about it through the traditional way, but good luck with the red tape ...or you can just get the right people together, get influence in the room that agrees with you and just get on with it, which is what we did" (Participant 5).

It was important during the planning stages to establish where the money and resources were to come from and this created many obstacles. For example: "we relied on staff volunteering their time in order to get this initiative off the ground and to keep it going to present day" (Participant 19), and: "if we had focussed on the bureaucracy and red tape, we would still probably be in the planning stages today" (Participant 3). This acknowledgement of the barriers in terms of structure and bureaucracy were also recognised as challenges to embed recovery-oriented practices further across the Trust, suggesting a bottom-up approach might have its limitations:

> "I acknowledge that as a [Trust] our main goal has never been recovery. Of course, we throw

around the buzz words, but it's not something that can be realistically implemented throughout the entire business because the actual people doing the work like HCAs (health care assistants) don't possess the relevant training or skills to transform the service alone". (Person 24)

However, in addition from learning from these lessons in the planning stages, it was also highlighted by participants how the process itself provided benefits, especially in terms of experience for service-users in this context that should be noted by others who may seek to follow a similar process:

> "Being seen as an equal, shown respect and given an opportunity through [setting up] the college has made me feel alive and I now have a purpose, giving me hope to breakaway from the Trust and seek other opportunities and support" (Participant 20).

Having a shared understanding of recovery

The data suggested that there was ambiguity in terms of how the RC defined recovery (of any type) during the development phase of the RC. There appeared to exist a shared general consensus that was not explicit or precise, which may have impacted the effectiveness of the early stages of the development process:

> "I'd like to imagine how I interpret recovery is how recovery is viewed by the recovery college. Coming together in a collaborative way to empower and instil hope and motivation via co-production. This is my opinion, although I've not really seen a definition" (Participant 21).

Another participant shared how they had not seen anything 'in print' with a definitive view of recovery to follow, which suggests planning and discussion occurred without the presence of a clear shared understanding to inform the collective work:

> "I don't know the exact definition. Can't say I've ever seen it in print. But being involved in the work of the recovery college, I've helped the service become more recovery focussed. Although there still remains conflict regarding this term, it's helped to design a recovery focused service. But this can be hit and miss, and there still exists a lot of cultural factors where certain members of staff still abide by the clinical definition of recovery" (Participant 4).

One participant highlighted a varying understanding of the term that was dependent upon job role:

> "The higher up the pay grade you go, the clearer it becomes that as an organisation, recovery is a huge 'buzz word' but very few people are actually able to hold a united definition of the term that is followed" (Participant 12).

It was also evident that being in the process of developing the college and it's early delivery was

helpful in shaping people's own recovery-oriented ideology:

> "I've worked for the recovery team and been in services in the past, [but] being in this environment has helped to build and shape my definition of recovery. I know that it involves the big three - hope, control and opportunity. On a personal level, it's about being in control of your illness rather than your mental illness being in control of you" (Participant 13).

Similarly, another participant stated how "I always thought that recovery was popping a pill and you're fine, but it's now seen to be so much more than that". (Participant 25). This suggests that the process of setting up the college had an impact upon those involved, almost in a transformational way considering how they conceptualised recovery. The process of developing the college could be seen as a catalyst that helped to crystalise the somewhat disparate perceptions of what recovery and recovery-oriented practice could be.

Conceptualisation of Recovery Colleges: Educational vs Therapeutic approaches

Adopting an educational rather than a therapeutic approach to delivery is fundamental in how recovery colleges function, as therapeutic approaches maintain a power imbalance with professionals (Perkins et al., 2012), whereas, an educational approach creates a shared learning space that is both open-ended and facilitative, enabling individuals to recognise and make use of their personal abilities and resources (McGregor et al., 2015). A common theme throughout the interviews was the conflicting opinions of how participants defined a recovery college. Participants found it challenging to articulate precisely whether the RC was educational or therapeutic (both in its conception and its early stages of delivery), but did share similar understandings that it was providing something very positive for the 'students'. For some it was considered a therapeutic endeavour both practically and ideologically:

> "I don't want to use the word therapeutic as in clinical therapy, but it's therapeutic as in the sense that it's a nice and relaxed environment. It's about equality and friendliness. So, it's sort of gaining the knowledge, but in a different sort of atmosphere rather than that of a training room or psychology session". (Participant 24)
>
> "It is not a medical or clinical intervention. But it's also not an academic course. And very much what people are getting I think from the sessions is the opportunity to talk and to share bits of their own experience and journey in an arena to discuss a topic in relation to their own experience or experience of others that they've known. So, I feel it's more a therapeutic approach than anything else." (Participant 12)

For other participants, the educational approach was much more evident:

> "At its heart it encompasses a strong educational theme, so, it's definitely educational. In

essence, they take an educational framework in the broadest sense of education to enable, encourage and support a wide range of participants to learn, grow and develop". (Participant 9)

"I think it is educational in the sense of it being part of lifelong learning. Do I think it's an opportunity to teach people? No. But that doesn't stop it being educational. My experience, both of the sessions that I attended as a learner and those that I led as a facilitator provided an opportunity for a group of people, no matter what label they came in the door with to share their experience on a particular topic and learn from one another. Enabling and introducing people perhaps to a new way of thinking about a particular topic or skill". (Participant 2)

The data demonstrated that there were differing perspectives on the planned approach of the RC, but given the issue of power imbalances highlighted by Perkins et al. (2012), those setting up a college need to be mindful of the co-production, quality assurance and framework of their idiosyncratic model, whilst also considering their context and collective needs, as this participant alluded to: "I think that there are lots of different models of recovery colleges over the country. And ours is very unique...I like the model we have" (Participant 9).

Discussion

This study is the first that has holistically explored the setting up of a recovery college from the perspectives of service-users, staff, carers and volunteers involved. Such insight from service-users, carers and volunteers add rich perspectives on what works well and considerations on possible areas of concern in service delivery. Staff perspectives are critical in trying to understand how provisions for recovery can be supported in mental health services, as they are responsible for understanding, interpreting, and implementing recovery policy (Hardiman and Hodges, 2008). The data implies that a process of co-production and co-design was implemented from the very first stage with the creation of the advisory group developed to facilitate mental health provision in becoming more recovery focused. By adapting a partnership approach and developing relationships with serviceusers, carers and volunteers, the RC as well as the wider Trust organisation can support and create opportunities for service-user involvement in providing consultancy on the planning and implementation of care provision (Bee et al., 2015) as well as opportunities to become involved in decision making.

The development of a recovery college stems from the growing need for mental health provision to become more recovery oriented (Meddings et al., 2015). When establishing a recovery paradigm Schwartz and Conklin (2015, p.480) stated how the "successful introduction of the recovery paradigm

may involve a process of inquiry and negotiation involving service providers and users that allows for mutual exploration of their different mental models and life experiences". Being aware of these differences is vital in ensuring that all models of care and differing recovery ideologies are considered at the design stage (Le Boutillier, 2017). Ramon (2011) states how an organisational shift in values, knowledge and skills is fundamental in promoting a recovery ethos across the mental health provision, therefore the data reflected the process of developing the college may have acted as a catalyst for the broader organisation to begin to move more towards being recovery-oriented.

In addition to the process of setting up the college developing the personal recovery appreciation of those involved, it highlighted the disparity of views on the purpose of the college in terms of being educational or therapeutic. It is understandable how comparisons of the two approaches have been made, as education can be therapeutic and therapeutic interventions can be educational. Therefore, this contrast could be seen as a heuristic one (Perkins et al., 2012). Hence, this is why it appears vital that when changing the structure and the culture of the service organisation in order for them to become recovery orientated it is vital that any recovery college first invests time defining its model and clarifying terminology. Recent reviews of literature (Theriault et al., 2019) and consideration of a recovery college fidelity model (Toney et al., 2019) are useful in informing this process, whilst still appreciating the local context and requirements. These conceptualisations are important because when designing and establishing a recovery college if some of the individuals involved in the process are aiming to develop an educational entity and others are trying to develop a therapeutic entity then the 'product' that emerges will lack coherence, which may impact upon sessions and even lead to potential tension amongst and between service-users, staff and carers involved. This might also be reflective of the infancy of the evidence base for recovery colleges, and as this particular recovery college began its early stages of development in 2015 its members were perhaps understandably less familiar with the emerging literature at the start of their process.

Conclusion

This study has demonstrated that, as well as future groups seeking to set up a recovery college having clear conceptualisations of personal recovery and the underpinning approach of their recovery college, they should also actively manage the level of integration between the college and its host organisation with open conversations about the power imbalances and roles of the serviceusers, staff, carers and volunteers involved. Those planning to develop a college should also be mindful that although there will be the early challenges as outlined in this study, there are broader benefits for both individuals and the wider organisation via the process of planning and discussions of how to implement co-produced, recovery-oriented practice such as a recovery college. Funding

The research project received funding from the Birmingham and Solihull Mental Health Foundation Trust Research and Innovation Fund.

Conflict of interest

On behalf of all authors, the corresponding author states that there is no conflict of interest.

References

Anfossi, A. (2017). *The Current State of Recovery Colleges in the UK*. Nottingham, UK: Implementing Recovery Through Organisational Change (ImROC).

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal,* 16(4), 11-23.

Bee, P., Brooks, H., Fraser, C., & Lovell, K. (2015). Professional perspectives on service user and carer involvement in mental health care planning: a qualitative study. *International Journal of Nursing Studies*, 52(12), 1834-1845.

Benkwitz, A., Morris, M., & Healy, L.C. (2019). An Ethnographic Study Exploring Football Sessions for Medium-Secure Mental Health Service-Users: Utilising the CHIME Conceptual Framework as an Evaluative Tool. *Journal of Psychosocial Rehabilitation and Mental Health*, 6(1), 55-65.

Boardman, J., Currie, A., Killaspy, H., & Mezey, G. (2010). *Social Inclusion and Mental Health*. London: Royal College of Psychiatrists.

Bourne, P., Meddings, S., & Whittington, A. (2018). An evaluation of service use outcomes in a recovery college. *Journal of Mental Health*, 27(4), 359-366.

Le Boutillier, C. (2017). Mental health staff perspectives on supporting recovery (Doctoral dissertation, King's College London).

Burhouse, A., Rowland, M., Niman, M., Abraham, D., Collins, E., Matthews, H., Denney, J., Ryland, H. (2015). Coaching for recovery: A quality improvement project in mental healthcare. *BMJ Open Quality,* 4:u206576.w2641. doi: 10.1136/bmjquality.u206576.w2641

Crotty, M. (1998). *The Foundation of Social Research: Meaning and Perspective in the Research Process*. London: SAGE.

Crowther, A., Taylor, A., Toney, R., Meddings, S., Whale, T., Jennings, H., Pollock, K., Bates, P., Henderson, C., Waring, J., & Slade, M. (2019). The impact of Recovery Colleges on mental health staff, services and society. *Epidemiology and Psychiatric Sciences,* 28(5), 481-488. https://doi.org/10.1017/S204579601800063X

Davidson, L. (2005). Recovery, self management and the expert patient-Changing the culture of mental health from a UK perspective. *Journal of Mental Health*, 14(1), 25-35.

Davidson, L., Ridgway, P., Wieland, M., & O'Connell, M. (2009). A capabilities approach to mental health transformation: A conceptual framework for the recovery era. *Canadian Journal of Community Mental Health*, 28(2), 35-46.

Department of Health (DoH) (2001). *The Journey to Recovery: The Government's Vision for Mental Health Care*. UK Department of Health.

Department of Health (DoH) (2009). “The Quality and Outcomes Framework”. http://www.dh.gov.uk/en/Healthcare/Primarycare/Primarycarecontracting/QOF/in dex.htm [Accessed: 21/6/2017]

Flick, U. (2013). *The SAGE handbook of qualitative data analysis*. London: SAGE.

Fontana, A., & Frey, J. H. (2000). The interview: From structured questions to negotiated text. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 645-672). Thousand Oaks, CA: SAGE.

Goldblatt, H., Karnieli-Miller, O., & Neumann, M. (2011). Sharing qualitative research findings with participants: Study experiences of methodological and ethical dilemmas. *Patient Education and Counseling*, 82(3), 389-395.

Hardiman, E. R., & Hodges, J. Q. (2008). Professional differences in attitudes toward and utilization of psychiatric recovery. *Families in Society,* 89(2), 220-227. https://doi.org/10.1606/1044-3894.3737

Hashagen, S., Kennedy, J., Paterson, A., & Sharp, C. (2011). *Doing with, not to: Community resilience and Co-production. The Implications for NHS Education for Scotland*. Scottish Community Development Centre.

King, T., & Meddings, S. (2019). ‘Survey identifying commonality across international Recovery Colleges', *Mental Health and Social Inclusion*, 23(3), 121-128. doi: 10.1108/MHSI-02-2019-0008

Larkin, M., & Thompson, A. R. (2012). Interpretative Phenomenological Analysis in mental health and psychotherapy research. In D. Harper & A. R. Thompson (Eds.), *Qualitative research method in mental health and psychotherapy: A guide for students and practitioners* (pp. 101-116). Chichester, UK: John Wiley & Sons.

Lieberman, J.A., Drake, R.E., Sederer, L.I., Belger, A., Keefe, R., Perkins, D., & Stroup, S. (2008). Science and recovery in schizophrenia. *Psychiatric Services*, 59(5), 487-496.

Lincoln, Y. S. (1990). The Making of a Constructivist: A Remembrance of Transformations Past. In: Guba, E. G. (ed.). *The Paradigm Dialog*. California: SAGE, 67-87.

McGregor, J., Repper, J., & Brown, H. (2014). ‘The College is so different from anything I have done'. A study of the characteristics of Nottingham Recovery College*. Journal of Mental Health Education, Training and Practice*, 9(1), 3-15.

Meddings, S., Byrne, D., Barnicoat, S., Campbell, E. & Locks, L. (2014). Co-Delivered and Co Produced: Creating a Recovery College in Partnership. *Journal of Mental Health Training, Education and Practice*. 9(1),16-25.

Meddings, S., McGregor, J., Roeg, W., & Shepherd, G. (2015). Recovery colleges: quality and outcomes. *Mental Health and Social Inclusion*. 19(1), 212-221.

Nurser, K., Hunt, D., & Bartlett, T. (2017). Do recovery college courses help to improve recovery outcomes and reduce self-stigma for individuals who attend*. Clinical Psychology Forum,* 300(1), 3237.

Perkins, R., Repper, J., Rinaldi, M. & Brown, H. (2012*). Recovery Colleges*. ImROC (Implementing Recovery through Organisational Change) Briefing Paper One. Centre for Mental Health / NHS Confederation.

Perkins, R., & Repper, J. (2017). When is a Recovery College not a Recovery College. *Mental Health and Social Inclusion*, 21(2), 65-72.

Ramon, S. (2011). Organisational change in the context of recovery-oriented services. *The Journal of Mental Health Training, Education and Practice*, 6 (1), 38-46.

Read, U. M., Adiibokah, E., & Nyame, S. (2009). Local suffering and the global discourse of mental health and human rights: an ethnographic study of responses to mental illness in rural Ghana. *Global Health*. 14(13), doi: 10.1186/1744-8603-5-13

Sands, R. R. (2002) *Sport Ethnography*. Leeds: Human Kinetics.

Schwartz, R., & Conklin, J. (2015). Competing paradigms: Exploring dialogue to promote interprofessional collaboration and transformation. *The Journal of Applied Behavioral Science*, 51(4), 479-500.

Shepherd, A., Shorthouse, O., & Gask, L. (2014). Consultant psychiatrists' experiences of and attitudes towards shared decision making in antipsychotic prescribing, a qualitative study. *BMC Psychiatry,* 14(1), 127. http://www.biomedcentral.com/content/pdf/1471-244X-14-127.pdf

Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., Perkins, R., Shepherd, G., Tse, S., & Whitley, R. (2014). Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry: Official journal of the World Psychiatric Association (WPA),* 13(1), 12-20. https://doi.org/10.1002/wps.20084

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, method and research*. London: SAGE.

Smith, J.A., & Osborn, M. (2003). Interpretative phenomenological analysis. In J.A. Smith (ed.), Qualitative Psychology. *A Practical Guide to Research Methods* (pp. 51-80). London: SAGE.

Sommer, J., Gill, K.H., Stein-Parbury, J., Cronin, P., & Katsifis, V. (2019). The role of recovery colleges in supporting personal goal achievement. *Psychiatric Rehabilitation Journal*, 42(4), 394.

Theriault, J., Lord, M.M., Briand, C., Piat, M., & Meddings, S. (2020). Recovery colleges after a decade of research: A literature review. *Psychiatric Services*, 71(9), 928-940.

Toney, R., Elton, D., Munday, E., Hamill, K., Crowther, A., Meddings, S., Taylor, A., Henderson, C., Jennings, H., Waring, J., & Pollock, K. (2018). Mechanisms of action and outcomes for students in Recovery Colleges. *Psychiatric Services*, 69(12), 1222-1229.

Toney, R., Knight, J., Hamill, K., Taylor, A., Henderson, C., Crowther, A., Meddings, S., Barbic, S., Jennings, H., Pollock, K., & Bates, P. (2019). Development and evaluation of a Recovery College fidelity measure. *The Canadian Journal of Psychiatry*, 64(6), 405-414.

Watson, D. P. (2012). The evolving understanding of recovery: what the sociology of mental health has to offer. *Humanity and Society,* 36(1), 290-308.