Psychiatric Rehabilitation Journal
2016, Vol. 39, No. 2, 187–190

1095-158X/16/$12.00 http://dx.doi.org/10.1037/prj0000179

BRIEF REPORT

The Recovery College: A Unique Service Approach and Qualitative Evaluation

Katherine Newman-Taylor
University of Southampton and Southern Health NHS Foundation Trust, Southampton, United Kingdom

Nicola Stone and Paul Valentine
Southern Health NHS Foundation Trust, Havant, United Kingdom

Zoe Hooks
University of Southampton

Katherine Sault
Southern Health Foundation Trust, Calmore, United Kingdom

Objective: This study examined the impact of a Recovery College, an educational service model focusing specifically on health care to engage people's hope, agency, and opportunities for recovery. ***Method:*** For the purpose of the study, a qualitative approach was used given the absence of research in this area. Eleven people completed semistructured interviews conducted by an independent researcher. Verbatim transcripts were analyzed using thematic analysis. ***Results:*** The analyses yielded themes emphasizing the impact of the organizational structure of the college. Coproduction of service delivery was contrasted with traditional provision and identified as fundamental to personal and professional changes made. ***Conclusions and Implications for Practice:*** Recovery College participants described clear gains. These findings are discussed in relation to the recovery literature and highlight the need for routine coproduction of services to facilitate recovery from the often devastating impact of mental ill-health.

Keywords: recovery, Recovery College, coproduction, qualitative evaluation

The quality and outcomes of mental health services are national priorities in the United Kingdom, the United States, and Canada (Department of Health, 2010, 2014; Kirby & Keon, 2006; President's New Freedom Commission on Mental Health, 2003). The U.K. Francis Report (Francis, 2013) identifies the nature of people's relationships with staff and the resultant experience of services as key to culture change required in provider organizations.

The recovery approach derives from service-user accounts and provides a clear direction for improving mental health provision. This model prioritizes self-management and personal recovery outcomes rather than traditional notions of cure from mental ill-health (Anthony, 1993; Deegan, 1988, 2004). The challenge is to coproduce services that prioritize hope, agency, and opportunity for purpose and social inclusion (Davidson, Ridgway, Wieland, & O'Connell, 2009; Repper & Perkins, 2003). Coproduction has its roots in the American civil rights movement, and involves shared planning and delivery of services in order to develop more effective and sustainable interventions for people with long-standing health conditions (Boyle & Harris, 2009; Realpe & Wallace, 2010). Coproduction in mental health is based on six principles: (a) taking an assets-based approach; (b) building on people's existing capabilities; (c) reciprocity and mutuality; (d) peer support networks; (e) blurring distinctions between professionals and recipients; and (f) facilitating rather than delivering services (Slay & Stephens, 2013).

The U.K. Department of Health states that it is only by establishing genuine partnerships between people with expertise through experience, and expertise through training, that we can deliver acceptable and effective services (Department of Health, 2010, 2011). With notable exceptions, it is disappointing that there is so little evidence of coproduced health care to date (Slay & Stephens, 2013).

Recovery Colleges are one example of coproduced services. Clinicians and service-users adopt an educational model to health care, and work together to develop and run courses that facilitate wellbeing and social inclusion. Courses are open to service-users, staff and service-users' families and friends (Perkins, Repper, Rinaldi, & Brown, 2012).

This article was published Online First May 5, 2016.

Katherine Newman-Taylor, Psychology Academic Unit, University of Southampton and Southern Health NHS Foundation Trust, College Keep, Southampton, United Kingdom; Nicola Stone and Paul Valentine, Southern Health NHS Foundation Trust, Hollybank, Havant, United Kingdom; Zoe Hooks, Psychology Academic Unit, University of Southampton; Katherine Sault, Southern Health Foundation Trust, Tatchbury Mount, Calmore, United Kingdom.

Thanks to Rochelle Sampson and all who took part in the study.

Correspondence concerning this article should be addressed to Katherine Newman-Taylor, Psychology Academic Unit, University of Southampton, Room 4068, Shackleton Building, Highfield Campus, Southampton SO17 1BJ, United Kingdom. E-mail: knt@soton.ac.uk

The present pilot was coproduced to assess the impact of a Recovery College in the South of England. The college is run as a further education college, with a focus on developing skills in recovery and self-management. Twenty-eight classes ran over the year of the evaluation, including "Values-based goal setting," "Managing crisis," and "From application to interview—gaining the job that you want." Courses are developed jointly by people with direct experience of mental ill-health and clinicians. Sessions are delivered as workshops from 2- hour to full-day sessions. The college is funded by the local NHS Trust and delivered from Trust bases.

To the authors' knowledge, there is no evidence for the impact of Recovery Colleges beyond anecdotal support, to date.

Method

Participants

Two groups of four students and one group of three students were interviewed. The majority were female ($n = 6$, 55%). Participants identified themselves as service-users ($n = 3$), staff ($n = 3$), service-users and staff ($n = 1$) and family/friends ($n = 2$). Two people declined to give this information. Participants were interviewed in mixed groups of service-users, staff, and family/friends.

Procedure

Invitations were sent to students considered likely to be willing to participate by course facilitators. One of the researchers led the group interviews (ZH). This researcher had no other connection with the college. A semistructured interview was used to prompt discussion.[1] These ran for approximately 45–60 min, and were audio-recorded.

Analysis

Interviews were transcribed verbatim and analyzed following thematic methods (Braun & Clarke, 2006). Transcripts were read several times for familiarity. Key ideas emerged and were discussed at length. Three of the researchers (NS, PV, and KNT) met to come to a consensus on the results. Initial codes developed into a clear set of overarching and subthemes. Clarity and consistency were sought, in line with best practice (Elliott, Fischer, & Rennie, 1999). The transcripts were then reread against the themes for reliability. A full codebook was compiled.[2]

Results

The qualitative analysis yielded an overarching theme of *connecting with others differently,* and three subthemes: *reflection on "stuckness"; quality of relationships enables change;* and *widening horizons.* This is shown in Figure 1.

Connecting With Others Differently

The overarching theme describes the way in which the ethos of the college facilitates change. Structural differences between coproduced services and traditional hierarchies (of clinicians and service-users) are recognized, and enable people to engage with each other in often unexpected ways: (a) to reflect on the "stuckness" of conventional roles; (b) to motivate personal and professional change; and (c) to look to the future.

Reflection on "stuckness." This describes the ways in which people had begun to reflect on their experiences, understand the process of change, and hold an awareness of new and hopeful possibilities.

> I became an illness, you know what I mean? (T3-147)

> You needn't be stuck, things can be different. . . . once you've come here . . . it opens the door. (T1-156–157)

> I had spent 14 weeks in an acute psychiatric ward and you're mixing with people as you say that are stuck . . . So for me it was brilliant to come along here and be with service-users that actually . . . were doing something about it. They weren't stuck and . . . that gives you hope in itself, aha! (T1-143–149)

Staff as well as service-users reflected on their "stuckness" in traditional roles, and the impact of more hopeful alternatives. These observations often led to consideration of change.

Quality of relationships motivates change. This describes how relationships within the Recovery College facilitated understanding of new perspectives and motivation for change.

> The very first course—it set the seeds in my mind that there was some hope . . . I wasn't going to rot for the rest of my life . . . I could grow and I've continued on that for 18 months . . . I was just so hopeless . . . and after that first course I did, I came away a slightly different person. (T1-259–265)

> I remember my mood dropping a bit, thinking, realizing actually, I am actually going to have to make lots of changes and I know it's not going to be easy. And it's down to me . . . I can't start blaming my husband or blaming whoever comes in front of me anymore. (T1-582–585)

> Actually one of the things I have found very beneficial . . . was having carers there. Because when you are unwell, you are so caught up in yourself, the world revolves around you, and the poor person looking after you, you can never see their point of view or anything, but you listen to carers on a course and see or what they are going through. (T1-359–363)

Contact with others at the college motivated change, even when this was aversive or required people to take others' perspectives rather than their own more familiar viewpoints. For some, this contributed to behavioral change.

Widening horizons. This describes means of "moving on." Through their interactions, students grew in confidence and made specific development plans.

> I do some work . . . with psychological therapy, trying to motivate people or commit to therapy . . . it's wonderful! Work now is not like work to me and it brings me enormous satisfaction . . . I get up every day full of zest for life . . . maybe that first morning that I came in here

[1] The interview is available on request. Examples of questions include: Has the College supported your recovery journey? Has it affected your sense of hope for the future? Has it affected your sense of agency or control over your life? Has it affected your opportunities to live well? Has it affected your relationships with others including staff, service users, friends and family?

[2] Available on request.

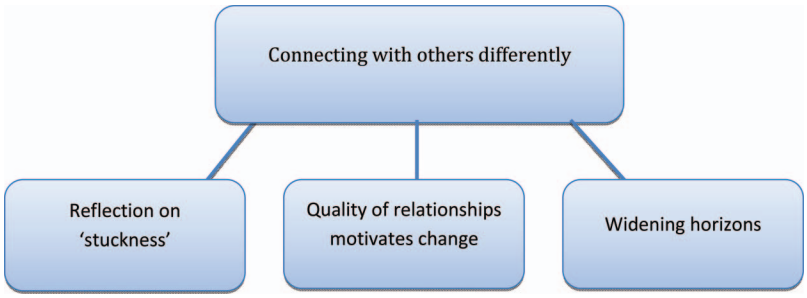

Figure 1. Impact of the Recovery College: Overarching theme and subthemes. See the online article for the color version of this figure.

> for, I'm not even sure I was well enough to be in here . . . I came out feeling very different, maybe that was the start of it. (T1-509–514)
>
> I've just signed up for another college course . . . if I hadn't had the confidence of coming here and succeeding here, I don't think I'd felt able to do another college course . . . I've signed up for an NVQ in teaching and supporting children in schools. (T2-133–136)
>
> What it has done is energized me. And I think hopefully by energizing me, and the work I do and the way I feel, that's then hopefully helping other people in their recovery, when I work with them. (T3-168–170)

Students made attitudinal and behavioral changes. The interest in contributing to others' wellbeing is striking.

Discussion and Conclusion

The data give a vivid account of the student experience and the impact on people's recovery. The overarching theme of connecting with others differently, implicit in the three subthemes, indicates that coproduction of courses and the college itself is key. This structure facilitated (a) reflection on periods of being "stuck"; (b) motivation for personal and professional change; and (c) attitudinal and behavioral changes as people looked to the future.

As a pilot and qualitative study with a small group of participants, there are limits to the generalizability of findings. There is likely to have been a selection bias: students identified as willing to participate may be biased in favor of the college. Others may not access the college and would give different reports. Nevertheless, this pilot suggests that the college facilitated the recovery of the people interviewed.

Coproduction of mental health care is still a relatively new approach, on the margins of public services (Slay & Stephens, 2013). Theoretical critique and the empirical literature remain underexamined. "Recovery" has been incorporated into policy narratives, and yet the historical and political context bears closer scrutiny, particularly the focus on individual responsibility for change at a time of crisis in health care provision (see Beresford, 2015; Morrow, 2013). The outcome literature is also modest. While there is preliminary evidence for the impact on social inclusion, mental and physical well-being, and costs (e.g., Repper, 2013; Shepherd, Boardman, Rinaldi, & Roberts, 2014; Slay & Stephens, 2013), larger scale longitudinal studies are needed. Recovery Colleges are one example of coproduced services, again lacking an evidence base. Given encouraging anecdotal evidence, more robust research is required in order to confirm the impact on recovery outcomes, and inform public funding decisions.

The present study provides initial support for the impact of coproduced services in the form of Recovery Colleges. In line with the literature, the qualitative data indicate that benefits include increased self-management skills and personal recovery outcomes (cf. Boyle & Harris, 2009; Deegan, 2004; Davidson et al., 2009; Repper & Perkins, 2003). The study also demonstrates that routine evaluation of health care provision can be coproduced. It has been our experience that coproduction has resulted in a more nuanced and effective evaluation (cf. Realpe & Wallace, 2010).

If supported by more systematic research base, Recovery Colleges may prove to be a model and catalyst for the wider organizational changes required if we are to establish the genuine coproduction in all aspects of health care.

References

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal, 16,* 11–23. http://dx.doi.org/10.1037/h0095655

Beresford, P. (2015). From 'recovery' to reclaiming madness. *Clinical Psychology Forum, 268,* 16–20.

Boyle, D., & Harris, M. (2009). *The challenge of co-production*. London, UK: New Economics Foundation.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3,* 77–101. http://dx.doi.org/10.1191/1478088706qp063oa

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,* 35–46. http://dx.doi.org/10.7870/cjcmh-2009-0021

Deegan, P. E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal, 11,* 11–19. http://dx.doi.org/10.1037/h0099565

Deegan, P. E. (2004, June). *Rethinking rehabilitation: Freedom*. Presentation at the 20th World Congress of Rehabilitation International: Rethinking Rehabilitation, Olso, Norway.

Department of Health. (2010). *Equity and excellence: Liberating the NHS* (White paper). London, UK: The Stationery Office.

Department of Health. (2011). *No health without mental health*. London, UK: The Stationery Office.

Department of Health. (2014). *Closing the gap: Priorities for essential change in mental health*. London, UK: The Stationery Office.

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related

fields. *British Journal of Clinical Psychology, 38,* 215–229. http://dx.doi.org/10.1348/014466599162782

Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust public inquiry*. London, UK: The Stationery Office.

Kirby, M. J., & Keon, W. J. (2006). *Out of the shadows at last: Transforming mental health, mental illness and addiction services in Canada*. Ottawa, ON: Canada Parliament Senate Standing Committee on Social Affairs, Science and Technology.

Morrow, M. (2013). Progressive paradigm or neo-liberal smokescreen? In B. Francois, R. Menzies, & G. Reaume (Eds.), *Mad matters: A critical reader in Canadian mad studies* (pp. 323–333). Toronto, ON: Canadian Scholars Press.

Perkins, R., Repper, J., Rinaldi, M., & Brown, H. (2012). *Recovery Colleges*. London, UK: Centre for Mental Health.

President's New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America*. White House.

Realpe, A., & Wallace, L. M. (2010). *What is co-production?* London, UK: The Health Foundation.

Repper, J. (2013). *Peer Support Workers: Theory and Practice*. London, UK: Centre for Mental Health and NHS Confederation Mental Health Network.

Repper, J., & Perkins, R. (2003). *Social inclusion and recovery: A model for mental health practice*. Kent, UK: Baillière Tindall.

Shepherd, G., Boardman, J., Rinaldi, M., & Roberts, G. (2014). *Supporting recovery in mental health services: Quality and outcomes*. London: Implementing Recovery Through Organisational Change.

Slay, J., & Stephens, L. (2013). *Co-production in mental health: A literature review*. London, UK: New Economics Foundation.

Received June 10, 2015
Revision received November 21, 2015
Accepted December 11, 2015 ■