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# Title: The impact of Recovery Colleges on mental health staff, services and society

Short title: Impact of Recovery Colleges

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## Abstract

### Aims

Recovery Colleges are opening internationally. The evaluation focus has been on outcomes for Recovery College students who use mental health services. However, benefits may also arise for: staff who attend or co-deliver courses; the mental health and social care service hosting the Recovery College; and wider society. A theory-based change model characterising how Recovery Colleges impact at these higher levels is needed for formal evaluation of their impact, and to inform future Recovery College development. The aim of this study was to develop a stratified theory identifying candidate mechanisms of action and outcomes (impact) for Recovery Colleges at staff, services and societal levels.

### Methods

Inductive thematic analysis of 44 publications identified in a systematised review was supplemented by collaborative analysis involving a lived experience advisory panel to develop a preliminary theoretical framework. This was refined through semi-structured interviews with 33 Recovery College stakeholders (service user students, peer/non-peer trainers, managers, community partners, clinicians) in three sites in England.

### Results

Candidate mechanisms of action and outcomes were identified at staff, services and societal levels. At the staff level, experiencing new relationships may change attitudes and associated professional practice. Identified outcomes for staff included: experiencing and valuing co-production; changed perceptions of service users; and increased passion and job motivation. At the services level, 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 giving experiential learning opportunities to staff around co-production and the role of a peer workforce. At the societal level, partnering with community-based agencies gave other members of the public opportunities for learning alongside people with mental health problems and enabled community agencies to work with people they might not have otherwise. Recovery Colleges also gave opportunities to beneficially impact on community attitudes.

**Conclusions**

This study is the first to characterise the mechanisms of action and impact of Recovery Colleges on mental health staff, mental health and social care services, and wider society. The findings suggest that a certain distance is needed in the relationship between the Recovery College and its host organisation if a genuine cultural alternative is to be created. Different strategies are needed depending on what level of impact is intended, and this study can inform decision-making about mechanisms to prioritise. Future research into Recovery Colleges should include contextual evaluation of these higher-level impacts, and investigate effectiveness and harms.

**Keywords/phrases**

Recovery Colleges; mental health staff; mechanisms of action; outcomes

## Introduction

Recovery Colleges are a global innovation in mental health systems. The concept of 'recovery education' – supporting recovery in relation to mental health problems through education – was developed in Boston and Phoenix in the 1990s. In the past decade a model of Recovery Colleges has emerged, with greater emphasis on co-production and co-learning. The first Recovery College opened in England in 2009, and there are now over 80 in the United Kingdom (Anfossi, 2017). This model has spread internationally, with Recovery Colleges now open or planned in 22 countries, e.g. Australian, Bulgaria, Canada, Hong Kong, Ireland, Italy, Japan, Netherlands, Norway, Poland and Uganda, among others (Perkins *et al.*, 2018).

Recovery Colleges involve supporting people living with mental health problems through adult education rather than through treatment (Perkins, 2012). The skills needed for living well with mental illness are relevant to anyone, so health professionals, family members and the public as well as service users attend colleges as students. Proportions vary, but for example in the first Italian Recovery College the student proportions were 63% service users, 19% family, 7% staff and 11% community members (Lucchi *et al.*, 2018). After registration, students attend self-selected courses co-delivered by peer trainers (people with personal experience of mental ill-health and recovery) and non-peer trainers (e.g. clinicians or topic experts). Recovery Colleges typically directly employ a small team of peer and mental health practitioners, with a larger group of peer trainers and practitioner trainers from mental health services and community agencies who are used on a sessional basis. Courses offered may cover understanding different mental health issues and treatment options, rebuilding life with mental health challenges, developing life skills and confidence to either rebuild life outside services or get the most out of services, capacity building and developing the peer workforce, and helping people to provide support for family members

and friends who experience mental health challenges Courses vary from brief, one-hour, introductory sessions to a day per week for a term (10 weeks) (Perkins *et al.*, 2018). A key feature of Recovery Colleges is the emphasis on co-production, i.e. people with lived experience co-produce all aspects of the college including curriculum development, quality assurance and delivering courses alongside a trainer with professional or topic-specific expertise.

The impact of Recovery Colleges can be stratified into four levels of social reality (Wikgren, 2005): student, staff, services and societal. The impact on students has been the primary motivation for developing Recovery Colleges, and in a separate paper we published a co-produced model of mechanisms of action and outcomes for students (Toney *et al.*, in press). Our focus in this study is on the other three levels. The staff level comprises Recovery College staff such as managers, administrators and trainers (including peer and non-peer trainers), and health professionals who attend courses. The services level comprises the mental health and social care system with which the Recovery College is usually, though not always, connected. The societal level is the wider family, community and social environment in which citizenship is enacted and stigma potentially experienced.

Publications about Recovery Colleges make claims for benefits at each level, but the scientific evidence base for Recovery Colleges is developing. Evaluations of experiences and outcomes at the student level have been the main focus, as they are the priority beneficiary group for Recovery Colleges. Research designs primarily comprise uncontrolled cohort studies, case series with pre- and post-test outcome assessment, and expert opinion (Australian Healthcare Associates, 2018). For example, a study of psychiatrists' views about the impact of Recovery Colleges on students showed general support, with the main concerns being about the relationship with the clinical system and attitudes to medication

adherence (Collins *et al.*, 2018). Although the overall weight of preliminary evidence is strongly positive (Australian Healthcare Associates, 2018, Meddings *et al.*, 2015b, Slade *et al.*, 2017), no randomised controlled trials have been conducted.

Very little research has addressed staff, services and societal levels. Staff-level evaluations are in general positive but do not use experimental methodologies. For example, a survey of 94 staff students, i.e. mental health workers attending Recovery Colleges as students, found 93% would recommend attendance to colleagues, with 54% self-identifying attitudinal change, 63% a positive impact on personal wellbeing, and 88% benefits for practice (Perkins *et al.*, 2017). Staff identify benefits from learning about the expertise of lived experience (Sommer *et al.*, 2018) and increasing their hopefulness about recovery (Newman-Taylor *et al.*, 2016), resulting in a positive impact on practice (Perkins *et al.*, 2018). For trainers, self-identified benefits include improved self-esteem and professional growth (Gill, 2014), and being inspired and transformed (Perkins *et al.*, 2018). Staff also self-report benefits in relation to morale, job satisfaction and reduced job-related stress (Sommer *et al.*, 2018).

At the level of services, the need for mental health system transformation in order to fully support recovery has been identified globally (United Nations General Assembly, 2017, World Health Organization, 2013). Recovery Colleges are proposed as a vehicle supporting this transformation towards recovery-oriented practice and co-production (Perkins *et al.*, 2018). The evidence base for service-level impact is very limited, although there is modest evidence of attitudinal shift in staff who are more involved in Recovery Colleges compared with those who are not (Rinaldi and Suleman, 2012), and staff identify positive impacts on organisational culture, e.g. in greater use of strength-based approaches (Sommer *et al.*, 2018) and more awareness of in-system stigma (McGregor *et al.*, 2016). Cost savings have

been suggested (Slade *et al.*, 2017), including reduced hospital use (Bourne *et al.*, in press) and staff sickness (Shepherd and McGregor, 2016).

No evaluative research has been published at the societal level. Candidate pathways of action include course attendance by family members and by non-mental health stakeholders, involvement of community organisations in co-delivering courses, governance arrangements (e.g. some Recovery Colleges are administered by further or higher education colleges or by community organisations), contributing to public mental health awareness (North Essex Research Network, 2014), and addressing community stigma (McGregor *et al.*, 2016).

Existing evaluations of Recovery Colleges do not specify or evaluate the causal mechanisms through which they are expected to operate. This creates challenges for implementation, fidelity and cross-cultural modification. The development of a theory-based change model specifying causal connections between mechanisms of action and outcomes in the related area of peer worker interventions (Gillard *et al.*, 2015) has substantially advanced peer worker-related research. The aim of this study was to develop a stratified theory identifying mechanisms of action and outcomes for Recovery Colleges at each of the staff, services and societal levels.

## Methods

The research reported here was part of the Recovery Colleges Evaluation, Characterisation and Testing (RECOLLECT) Study (researchintorecovery.com/recollect). Ethics Committee approval was obtained (Nottingham REC 1, 18.1.17, 16/EM/0484). All participants provided informed consent.

**Setting**

Three Recovery Colleges chosen for geographical and demographic diversity: Leicestershire (opened 2013, 1,446 students in 2016/2017, mixed urban/rural catchment), South London and Maudsley (SLAM) (opened 2015, 348 students in 2016/2017, highly urban) and Sussex (opened 2013, 1,800 students in 2016/2017, mixed urban/rural). All are open to current/previous secondary mental health service users, staff and carers (family/friends), and Sussex is also open to any community member.

**Data collection and analysis**

A coding framework was iteratively developed using systematised review, inductive and collaborative analysis of included papers, and semi-structured interviews with stakeholders.

A systematised literature review was conducted. Inclusion criteria: primary focus on Recovery Colleges; online publication 2016 or earlier; electronic version available; English-language. Exclusion criterion: College prospectus, newspaper articles. Sources: existing repository of academic publications (researchintorecovery.com/rcrg); expert consultation (n=67); conference abstracts (Refocus on Recovery 2010/2012/2014/2017, ENMESH 2011/2013/2015); reference lists and citations of included publications (via Web of Science). Most publications addressed impact only at service user student level, so the sub-set of key papers addressing the other levels were identified by the research team. Inductive thematic analysis on key papers was conducted by one coder, and then refined through discussion with the research team (n=5) including expert qualitative researchers.

To ensure lived experience informed the analysis, we separately used a collaborative analysis methodology (Cornish *et al.*, 2013) in a workshop with nine service users and carers to identify candidate mechanisms of action and outcomes at any level (Jennings *et al.*,

2018). Minutes, flipchart outputs and researcher field notes from the workshop were used to identify themes, which were integrated into the analysis of the key publications to produce a preliminary framework characterising mechanisms of action and outcomes at staff, services and societal levels.

To refine the framework, semi-structured interviews were then conducted with stakeholders from the three study sites, comprising: people directly involved with Recovery Colleges, i.e. managers, peer trainers with lived experience, non-peer trainers with professional or topic-specific expertise, students; community-based and mental health service-based partners; and commissioners. The preliminary framework informed the topic guide. Each interview lasted 30-60 minutes, and involved open questions about mechanisms and outcomes at the three levels, followed by questions about the validity and comprehensiveness of the preliminary framework. Interviews were recorded, transcribed and coded using NVivo 11 by three researchers using six pre-defined superordinate codes (mechanisms and actions for staff, services and societal levels). Themes were coded at the relevant level (staff, services, societal) independent of the participant's perspective (e.g. student, staff, etc.). After nine transcripts were coded, researchers met to compare and merge coding frameworks. The refined framework was applied to all remaining transcripts, with iterative discussion and further refinement to produce the final coding framework for each level.

## Results

Forty-four publications were included (online supplement 1). No publication empirically investigated the research question, and most were non data-based articles, e.g. descriptions of the process of creating a college. Thirty-eight (86%) were from England, and only two (5%) involved research in more than two colleges (King, 2015, McGregor *et al.*, 2016).

Ten key publications were identified, shown in Table 1.

Insert Table 1 here

The service user and carer workshop identified mainly student-level mechanisms and outcomes, reflecting their focus. The workshop identified only one societal outcome: reduced stigma in the community and in the family. This proposal and the inductive analysis of key publications were integrated to develop the preliminary framework (shown in online supplement 2), identifying candidate mechanisms (2 staff, 3 services, 3 societal) and outcomes (5 staff, 2 services, 4 societal) at each level.

The preliminary framework was refined through interviews (n=33) with service user students (n=11), peer trainers (n=4), clinician trainers (n=4), Recovery College managers (n=2), community partner organisations (n=4), commissioners (n=4), National Health Service (NHS) (i.e. host organisation) managers (n=2) and NHS clinicians (n=2). Service user students primarily described student-level impact, so most coding reported here emerged from non-student participants. The key themes are discussed here, and a more complete description of text for each code is given in online supplement 3.

**Staff level**

The final coding framework for the staff level is shown in Table 2.

Insert Table 2 here

The most frequently proposed mechanism of change for staff was a softening of established

roles, which was linked to the environment and to staff-student interactions in attending and delivering courses.

> You forget you're a social worker…you're just a person in a room learning about something that is important to you. (Clinician and staff student #1)

> …professionals…learn to see service users in a slightly different light (Peer trainer #1)

Resulting changes in professional practice for non-peer staff included new approaches to working with and relating to service users, and a re-engagement with their commitment to the work. Co-production was identified as having a specific impact.

> There was the sense…there has to be something better than this for me personally as a clinician... it [Recovery College]…opened up my eyes again. (Non-peer trainer #3)

> I will think, everything I do now, let's look at about how we can co-produce this...God, my mindset has absolutely shifted (NHS manager #1)

Some non-peer tutors struggled with the role.

> It's sometimes been a challenge when the professional has taken over (NHS manager #1)

A beneficial impact on staff wellbeing was identified by trainers, though the level of responsibility was problematic for some peer trainers.

> Without it [working at the Recovery College] I would've been even more sort of fed up and stressed. (Non-peer trainer #3)

> Some people [peers] couldn't, sort of, cope with it… (Peer trainer #4)

**Services level**

The final coding framework for the mental health and social care services level is shown in Table 2.

Insert Table 2 here

Many Recovery Colleges develop in a protected and low-visibility space within the host organisation, allowing them to grow un-hindered: "I don't think anybody particularly noticed [the college]" (Non-peer trainer #3). Positive risk-taking encouraged in Recovery Colleges was identified as a specific difference from the risk aversion of the wider organisation, increasing the perceived distance between the college and other services. Differences between the college and wider system were not viewed as a wholly negative, as it allowed the organisation to give a positive impression of hosting a socially desirable recovery initiative.

> So that's the challenge to the traditional psychiatric medical model, which is still there in every single team… (NHS manager #1)

> There was a near neighbour which already had a college so they would have been very much aware of that, and I think that got good publicity. (Commissioner #3)

The most frequently-coded service outcome was increased co-production. Linked to this was the impact on peer workforce development within services, with lowered discriminatory assumptions about the abilities of workers with lived experience and more willingness to make workplace adjustments. The possibility of workforce exploitation was noted, along with concerns about how far Recovery Colleges would spread.

> Everything we do is in line with peers…the cultural effect of the Recovery College on this organisation has been a proliferation of co-production. (NHS manager #1)

> there would be…resistance at it becoming a dominant way of delivering services…because of the tendency everywhere to fall to the status quo. (Commissioner #2)

**Societal level**

The final coding framework for the societal level is shown in Table 4.

Insert Table 4 here

The most frequently coded mechanism was working with community organisations to co-produce courses. This was nearly always described as positive, though adapting courses to Recovery College requirements was sometimes challenging for the community partner. This enabled community organisations to engage with students they might not otherwise have worked with:

> So it's really helpful to be able to do what we do with a different group of people. (Community partner organisation #3)

The most frequently reported impact of Recovery Colleges was on public attitudes, by reducing negative assumptions about people with mental health problems. Increased social inclusion through more friendships and better integration into the community was proposed. Benefits for community organisations from working with Recovery Colleges were also identified, through increased public access to their services and increased co-production in their own work.

> It allows people to…be involved a bit more in the community. (Community partner organisation #4)

> Because if they [community partner] see how well it [co-production] works…they're more likely to go back and think "Oh OK that's how we should do things again" really. (Recovery College Manager #2)

**Discussion**

This is the first study to use mixed-methods research to identify candidate mechanisms of action and outcomes for Recovery Colleges at staff, services and societal levels. Inductive document analysis and interviews with a wide range of Recovery College stake-holders identified candidate mechanisms of action and outcome at each level.

**Change at the staff level**

The richest data were elicited for changes in staff. Staff involvement in a Recovery College, including attending and co-running courses, has the potential to impact on staff attitude and behaviour, e.g. towards co-production and shared decision-making (Slade, 2017). Specific examples were positive interactions with peer trainers and experiencing co-production. This

may be viewed as an approach to reducing in-system stigma, that is stigmatising beliefs held by health professionals in relation to people with mental ill-health (Henderson *et al.*, 2014). Clinicians meeting service users in traditional clinical contexts does not improve attitudes (Thornicroft *et al.*, 2016). It is plausible that the intergroup contacts between staff and service user in a Recovery College context have more prejudice-reducing features: participants have equal status; co-operation around common goals is encouraged; contact is normative, i.e. has institutional support; and meaningful repeated contacts support friendship development (Al Ramiah and Hewstone, 2013).

Peer work is an important global innovation in the mental health system (Puschner, 2018). A change model for peer workers has been developed (Gillard *et al.*, 2015), but not yet specifically for peer trainers. Similarly, co-production is a new way of transforming systems, but recent evaluations indicate it is complex to implement (Parker *et al.*, 2018). A primary impact of Recovery Colleges on staff arises from seeing these two innovations in practice.

**Change at the service level**

Recovery Colleges in England have emerged without central commissioning and in the context of economic austerity when many mental health and social care systems are under considerable financial pressure. Two mechanisms emerged as influential at the system level: organisational separation and organisational image.

The separation of Recovery Colleges from its host institution has potential negative impacts, such as low staff awareness about the Recovery College and reduced opportunity to impact on mainstream services (Zabel *et al.*, 2016). However, participants identified as more significant the benefit of separation in allowing the creation and sustaining of a different organisational culture, based on educational rather than clinical concepts, and using co-

production rather than solely professional views to lead the service. Insufficient separation has been shown to reduce fidelity in other alternative systems, such as consumer-run services (Segal and Hayes, 2016).

The emergence of organisational image as an influence on uptake may explain the success of Recovery Colleges in opening in England during a period of austerity – Recovery Colleges both meet the goal of having a demonstrable service focussed on recovery in alignment with national policy (HM Government, 2011) and the group-level process of social desirability (neighbouring organisations have one so we should have one).

Both these mechanisms can be seen as arising from the Recovery College features of being a discrete new approach which need not disrupt existing service culture. However, it has been argued that viewing recovery as something 'done' in one part of an organisation fails to engage with the need for cross-organisation transformation (Slade *et al.*, 2014). Recent challenges to traditional mental health systems (United Nations General Assembly, 2017) indicate that this separation may be a short-term approach to allow Recovery Colleges to flourish, but longer-term the wider system culture needs to be transformed before colleges can both flourish and be fully integrated.

**Change at the societal level**

Mechanisms and outcomes at the societal level were least considered, perhaps indicating that the focus of most participants was in-system transformation. All identified mechanisms involved increased interaction between mental health stakeholders and wider community stakeholders, and the most identified beneficial outcome related to stigma. The experience of discrimination by people with mental health problems is widespread (Webber *et al.*, 2014) (Corker *et al.*, 2016), and anti-stigma initiatives have the potential to impact on service users'

responses to discrimination (Sampogna *et al.*, 2017). Recovery Colleges and anti-stigma programmes share the aim of increased community participation as a result of reduced discrimination and reduced self-stigma. The extent to which Recovery Colleges can improve community attitudes towards mental ill-health merits further investigation.

The study has several strengths. It is the first study to address the multiple levels at which Recovery Colleges have an impact. It was developed using both primary and secondary data to enhance validity, used a range of stakeholder perspectives, and included consideration both of positive and negative mechanisms and outcomes. A limitation of the study is the challenge of separating impact at different levels. Respondent attributions of change to staff versus change in the system may constitute a category error. Other limitations are the small, albeit diverse, sample who are likely to have self-selected for their positive views, the absence of family perspectives, and the potential bias arising from involvement of some authors in Recovery Colleges.

**Future research**

This study can be extended in three ways. First, it provides a preliminary theory base for the future development of a testable change model at each level. Developing a change model is necessary for formal evaluation of the impact of Recovery Colleges at each level. The next step will involve creating a formal change model showing proposed connections between specific mechanisms and measurable outcomes. It is likely that causal connection will emerge between different levels. For example, improved student outcomes may positively impact on staff hopefulness about recovery, on service culture by raised expectations about shared decision-making, and on societal outcomes through more visible contributions by people with mental health problems in local communities. The resulting change model will then need to be validated by feedback from stakeholders. Our study suggests that, for this

specific research question, service user students should not be the main stakeholder group as their focus is on the student level. The final stage will then involve observational or experimental research to test the change model in practice.

Second, we noted the absence of consideration in reviewed publications of potential harms from Recovery Colleges, presumably because as with any health innovation, a very positive message about the content and potential benefit of the intervention is initially needed. Stakeholder interviews highlighted a range of possible negative consequences, such as exploitation of peer workers. This suggests that the field is maturing and some potentially negative consequences are becoming visible. Future Recovery College evaluations should investigate and report (Ioannidis *et al.*, 2004) unwanted effects as well as benefits.

Finally, our identification of candidate mechanisms and outcomes at each level can inform the evaluation of Recovery Colleges. The key outcomes to emerge are staff perceptions about service users, service-level use of co-production and development of a peer workforce, and public attitudes. Each of these outcomes is measurable and can inform a more contextual evaluation in a randomised controlled trial (Moore *et al.*, 2014).

**Implications**

This study has implications for new and existing Recovery Colleges. Investing in Recovery Colleges has the potential not only to benefit mental health service users. A range of outcomes for mental health staff and services and wider society has been identified. The resulting framework can inform commissioning and organisational arrangements.

The level of integration between the college and the host should be actively managed. Aspects to consider include shared versus separate buildings, paperwork, processes and

workforce. A protected space enables the college to develop a distinct counter-culture, but closer integration increases the extent to which the Recovery College will influence culture in the host organisation.

If the main focus is on beneficial impacts on the mental health and social care system, then the distinct identity of the Recovery College needs to be actively managed, staff encouraged to view their Recovery College experiences as providing them with experiential resources to be used in the host organisation, and efforts made to invite co-production and peer workforce developments in the host organisation. Similarly, if the focus is on societal change, then courses specifically targeted at family and community members, and active engagement with community agencies are priorities.

The potential benefits of Recovery College beyond mental health service users are coming into focus. This study provides a first theoretical foundation for investigating Recovery Colleges as an approach to organisational and societal transformation.

## Availability of Data and Materials

Data are available from the corresponding author.


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## Conflicts of Interest

None.

## Ethical Standards

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008.

## Availability of Data and Materials

Available from corresponding author.

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**North Essex Research Network** (2014). *Evaluation of the Mid Essex Recovery College October – December 2013*. NERN: Essex.

**Oh, H.** (2013). The pedagogy of recovery colleges: clarifying theory. *Mental Health Review Journal* **18**, 240.

**Parker, S., Dark, F., Newman, E., Hanley, D., McKinlay, W. & Meurk, C.** (2018). Consumers' understanding and expectations of a community-based recovery-oriented mental health rehabilitation unit: a pragmatic grounded theory analysis. *Epidemiology and Psychiatric Sciences* **doi:10.1017/S2045796017000749**.

**Perkins, A., Ridler, J., Hammond, L., Davies, S. & Hackmann, C.** (2017). Impacts of attending recovery colleges on NHS staff. *Mental Health and Social Inclusion* **21**, 18-24.

**Perkins, R., Meddings, S., Williams, S. & Repper, J.** (2018). *Recovery Colleges 10 Years On*. ImROC: Nottingham.

**Perkins, R., Repper, J.** (2017). When is a "recovery college" not a "recovery college"? *Mental Health and Social Inclusion* **21**, 65-72.

**Perkins, R., Repper, J., Rinaldi, M., Brown, H.** (2012). *ImROC 1. Recovery Colleges*. Centre for Mental Health: London.

**Puschner, B.** (2018). Peer support and global mental health. *Epidemiology and Psychiatric Sciences* **shep27**, 413-414.

**Rinaldi, M. & Suleman, M.** (2012). *Care co-ordinators attitudes to self-management and their experience of the use of the South West London Recovery College*. South West London and St George's Mental Health NHS Trust: London.

**Sampogna, G., Bakolis, I., Robinson, E., Corker, E., Pinfold, V., Thornicroft, G. & Henderson, C.** (2017). Experience of the Time to Change programme in England as predictor of mental health service users' stigma coping strategies. *Epidemiology and Psychiatric Sciences* **26**, 517-525.

**Segal, S. & Hayes, S.** (2016). Consumer-run services research and implications for mental health care. *Epidemiology and Psychiatric Sciences* **25**, 410-416.

**Shepherd, G. & McGregor, J.** (2016). Recovery Colleges – Evolution or Revolution? In *Vlaamse Vereniging Geestelijke Gezondheidszorg*: Ghent.

**Skipper, L. & Page, K.** (2015). Our recovery journey: two stories of change within Norfolk and Suffolk NHS Foundation Trust. *Mental Health and Social Inclusion* **19**, 38-44.

**Slade, M.** (2017). Implementing shared decision making in routine mental health care. *World Psychiatry* **16**, 146-153.

**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* **13**, 12-20.

**Slade, M., McDaid, D., Shepherd, G., Williams, S. & Repper, J.** (2017). *ImROC Briefing Paper 14. Recovery: the Business Case*. ImROC: Nottingham.

**Sommer, J., Gill, K. & Stein-Parbury, J.** (2018). Walking side-by-side: Recovery Colleges revolutionising mental health care. *Mental Health and Social Inclusion* **22**, 18-26.

**Taggart, H. & Kempton, J.** (2015). *The route to employment: the role of mental health recovery colleges*. CentreForum: London.

**Thornicroft, G., Mehta, N., Clement, S., Evans-Lacko, S., Doherty, M., Rose, D., Koschorke, M., Shidhaye, R., O'Reilly, C. & Henderson, C.** (2016). Evidence for effective interventions to reduce mental-health-related stigma and discrimination. *Lancet* **387**, 1123-1132.

**Toney, R., Elton, D., Munday, E., Hamill, K., Crowther, A., Meddings, S., Taylor, A., Henderson, C., Jennings, H., Waring, J., Pollock, K., Bates, P. & Slade, M.** (in press). Mechanisms of action and outcomes for students in Recovery Colleges. *Psychiatric Services*.

**United Nations General Assembly** (2017). *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. Human Rights Council: New York.

**Watson, E.** (2013). *What Makes a Recovery College? A Systematic Literature Review of Recovery Education in Mental Health*. MHSC Dissertation: Nottingham.

**Webber, M., Corker, E., Hamilton, S., Weeks, C., Pinfold, V., Rose, D., Thornicroft, G. & Henderson, C.** (2014). Discrimination against people with severe mental illness and their access to social capital: Findings from the Viewpoint survey. *Epidemiology and Psychiatric Sciences* **23**, 155-165.

**Wikgren, M.** (2005). Critical realism as a philosophy and social theory in information science? *Journal of Documentation* **61**, 11-22.

**World Health Organization** (2013). *Mental Health Action Plan 2013-2020*. WHO: Geneva.

**Zabel, E., Donegan, G., Lawrence, K. & French, P.** (2016). Exploring the impact of the recovery academy: a qualitative study of Recovery College experiences. *Journal of Mental Health Training, Education and Practice* **11**, 162-171.

## Table 1: Key papers included in document analysis (n=10)

| Reference | Peer-reviewed? | Empirical data? | Author perspective(s) | Method | Participant type | Sample size (*n*) | Country | No. of Recovery Colleges (*n*) |
|---|---|---|---|---|---|---|---|---|
| (Frayn *et al.*, 2016) | Yes | No | RC staff | Mixed | Students and staff (with and without lived experience) | 8 | UK | 1 |
| (Perkins, 2017) | Yes | No | Staff | N/A | N/A | N/A | UK | N/A |
| (Meddings *et al.*, 2015a) | Yes | Yes | Staff and student | Quantitative | Students | 35 | UK | 2 |
| (Taggart and Kempton, 2015) | No | No | Staff | N/A | N/A | N/A | UK | N/A |
| (North Essex Research Network, 2014) | No | Yes | Mental health researchers, Service User Research Group | Mixed | Students | 47 | UK | 1 |
| (Dorset Wellbeing and Recovery Partnership, 2016) | No | No | Clinicians and peer workers | N/A | N/A | N/A | UK | N/A |
| (McGregor *et al.*, 2014) | Yes | Yes | Manager, staff, researcher | Mixed | Students, peer-support workers, volunteers and staff | N/A | UK | 1 |
| (Oh, 2013) | Yes | No | Researcher | N/A | N/A | N/A | UK | N/A |
| (Skipper and Page, 2015) | Yes | No | NHS Project lead, student, peer support worker | Qualitative | NHS Project lead, student, peer support worker | 2 | UK | 2 |
| (Watson, 2013) | No | No | Postgraduate researcher | Qualitative | N/A | N/A | UK | N/A |

**Table 2: Final coding framework for staff level mechanisms of action and outcomes**

**Mechanisms of action for staff**

1. Equality and humanness
    - 1.1 Co-production of courses
    - 1.2 Doing 'with' not 'to' service users
2. Empowering staff environment
    - 2.1 Making a difference
    - 2.2 Receiving support and supervision
    - 2.3 Experiencing a dynamic, creative environment
    - 2.4 Having responsibility
3. Staff working style
    - 3.1 Honesty and sharing experiences
    - 3.2 Demonstrating a commitment to recovery
    - 3.3 Working from theories of adult learning
4. Staff attend courses as students

**Outcomes for staff**

1. Professional practice
    - 1.1 Perceptions of service users
    - 1.2 Passion and motivation
    - 1.3 Co-production
    - 1.4 Language
2. Wellbeing
    - 2.1 Peer wellbeing and recovery
        - 2.1.1 Career progression
        - 2.1.2 Confidence and empowerment
        - 2.1.3 Knowledge and tools
    - 2.2 Non-peer staff wellbeing

**Table 3: Final coding framework for services level mechanisms of action and outcomes**

**Mechanisms of action for services**

1. Degree of integration with other services
    - 1.1 Development in isolation
        - 1.1.1 Risk aversion
        - 1.1.2 Resistance to change
    - 1.2 Close integration with NHS services
2. Challenging traditional models of mental healthcare
    - 2.1 Positive risk-taking
3. Opportunism and image management
4. Strategic partnerships with external organisations
5. Leadership

**Outcomes for services**

1. Co-production
2. Peer workforce
    - 2.1 Discrimination
    - 2.2 Cheap labour and non-substantive posts
3. Service development
    - 3.1 Expertise and influence
    - 3.2 Recovery-oriented practice
    - 3.3 Filling a gap in provision
    - 3.4 Partnership working
4. Attitudes and beliefs
    - 4.1 Language
5. Cost and resource savings

**Table 4: Final coding framework for mechanisms of action and outcomes**

| |
|---|
| **Societal mechanisms of action** |
| 1. Working with community organisations |
| 1.1 Co-production with community organisations |
| 1.2 Community organisations work with new groups of people |
| 2. Public involvement |
| **Societal outcomes** |
| 1. Public attitudes and awareness |
| 1.1 Stigma and discrimination |
| 1.2 Social inclusion |
| 1.3 Public profile of Recovery Colleges |
| 1.4 Public mental health awareness |
| 2. Benefits for community organisations |
| 2.1 New community pathways |
| 2.2 Co-production |
| 3. Impact on friends, family and carers |
| 4. Employment and volunteering |

# Online Supplement 1
# Included publications (n=44)

| # | Full reference | Peer-reviewed? | Presents empirical data? | Author perspective | Method | Participants | Sample size | Setting | Number of Recovery Colleges article is based on |
|---|---|---|---|---|---|---|---|---|---|
| | **KEY PAPERS** | | | | | | | | |
| 1 | Frayn E, Duke J, Smith H, Wayne P, Roberts G (2016) *A voyage of discovery: setting up a recovery college in a secure setting*, Mental Health and Social Inclusion, **20**, 29-35. | Y | N | Staff | Mixed methods | Students, Staff (with and without lived experience) | 8 | UK | 1 |
| 2 | Perkins R, Repper J (2017) *When is a "recovery college" not a "recovery college"?,* Mental Health and Social Inclusion, **21**, 2, 65-72. | Y | N | Staff | N/A (Not applicable) | N/A | N/A | UK | N/A |
| 3 | Meddings S, Campbell E, Guglietti S, Lambe H, Locks L, Byrne D, Whittington A (2015) *From service user to student: the benefits of Recovery Colleges*, Clinical Psychology Forum, **268**, 32-37. | Y | Y | Staff and Student | Quantitative | Students | 35 | UK | 2 |
| 4 | Taggart H, Kempton, J (2015) *The route to employment: the role of mental health recovery colleges,* London: CentreForum. | N | N | Staff | N/A | N/A | N/A | UK | N/A |
| 5 | North Essex Research Network (2014) *Evaluation of the Mid Essex Recovery College October – December*, Essex. | N | Y | Mental health researchers, Service User Research Group | Mixed methods | Students | 47 (17) | UK | 1 |
| 6 | The Dorset Wellbeing and Recovery Partnership (WaRP) (2016) *WaRP Magazine,* http://www.dorsetmentalhealthforum.org.uk/pdfs/WaRP%20Magazine%20September%202016.pdf Accessed 24.04.2017. | N | N | Clinicians and peer workers | N/A | N/A | N/A | UK | N/A |
| 7 | McGregor J, Repper J, Brown H (2014) *"The college is so different from anything I have done". A study of the characteristics of Nottingham* | Y | Y | Manager, Staff, Researcher | Mixed methods | Students, peer support workers, volunteers, staff | N/A | UK | 1 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | *Recovery College,* Journal of Mental Health Training, Education and Practice, **9**, 3-15. | | | | | | | | |
| 8 | Oh H (2013) *The pedagogy of recovery colleges: clarifying theory,* Mental Health Review Journal, **18**, 240. | Y | N | Researcher | N/A | N/A | N/A | UK | N/A |
| 9 | Skipper L, Page K (2015) *Our recovery journey: two stories of change within Norfolk and Suffolk NHS Foundation Trust,* Mental Health and Social Inclusion, **19**, 1, 38 – 44. | Y | N | Trust project lead, student, peer support worker | Qualitative | Trust Project Lead, Student and PSW | 2 | UK | 2 |
| 10 | Watson E (2013) *What Makes a Recovery College? A Systematic Literature Review of Recovery Education in Mental Health*, Nottingham: MHSC Dissertation. | N | N | Postgraduate researcher | Qualitative | N/A | N/A | UK | N/A |
| | **OTHER INCLUDED PAPERS** | | | | | | | | |
| 11 | Kelly J, Gallagher S, McMahon J (2017) *Developing a recovery college: a preliminary exercise in establishing regional readiness and community needs*, Journal Of Mental Health, **26**, 150-155. | Y | Y | MH Researchers | Mixed methods | Staff, service users, allied professionals, family and friends, volunteers | 254 | UK | N/A |
| 12 | Dunn E A, Chow J, Meddings S, Haycock L J (2016) *Barriers to attendance at Recovery Colleges,* Mental Health and Social Inclusion, **20**, 4, 238-246. | Y | Y | Staff (Clinicians/Professionals working at Health organisations) | Mixed methods | Students | 16 | UK | 1 |
| 13 | Hall T, Brophy L, Jordan H (2016) *A report on the preliminary outcomes of the Mind Recovery College*, The University of Melbourne, Centre for Mental Health. | N | N | Researchers | Mixed methods | Students, families, carers, staff member | 54 | Australia | 1 |
| 14 | Hall T, Brophy L, Jordan H, Hardy D, Belmore S, Scott A, Thompson H (2016) *Co-Producing The Journey To Recovery: The Mind Recovery College*, Australia: TheMHS Conference 2016 Book of Proceedings. | Y | Y | Evaluation team | Mixed methods | Students, families,carers,community stakeholders | 54 | Australia | 1 |
| 15 | McGregor J, Brophy L, Hardy D, Hoban D, Meddings S, Repper J, Rinaldi M, Roeg W, Shepherd G, | N | N | Recovery College stakeholders | N/A | N/A | N/A | UK | Multiple |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Slade M, Smelson D, Stergiopoulos V, RCICoP Group (2016) *Proceedings of June 2015 Meeting*, Recovery Colleges International Community of Practice (RCICoP). | | | | | | | | |
| 16 | Mind (2016) *Australasian Recovery College Community of Practice Inaugural Meeting*, Victoria: Mind. | N | N | Recovery College Staff | N/A | N/A | N/A | Australia | N/A |
| 17 | Newman-Taylor K, Stone N, Valentine P, Hooks Z, Sault K (2016) *The Recovery College: A unique service approach and qualitative evaluation*, Psychiatric Rehabilitation Journal, **39**, 2, 187-190. | Y | Y | NHS Staff | Qualitative | Students | 11 | UK | 1 |
| 18 | Shepherd G, McGregor J (2016) *Recovery Colleges – Evolution or Revolution?*, Ghent, November 9. | N | N | Senior Consultants (ImROC) | N/A | N/A | N/A | UK | N/A |
| 19 | Sussex Recovery College (2016) *Performance and Evaluation Report (Summer Term 2016)*, Brighton: Sussex Partnership NHS Foundation Trust. | N | Y | ? | Quantitative | Students | Varies per analysis | UK | 2 |
| 20 | Thornhill H, Dutta A (2016) *Thematic paper: Are recovery colleges socially acceptable?*, BJPysch International, **13**, 6-7. | Y | N | NHS Staff | N/A | N/A | N/A | UK | N/A |
| 21 | Zabel E, Donegan G, Lawrence K, French P (2016) *Exploring the impact of the recovery academy: a qualitative study of Recovery College experiences*, Journal of Mental Health Training, Education and Practice, **11**, 162-171. | Y | Y | Research and NHS staff | Qualitative | People with lived experience, family members, staff and health professionals | 21 | UK | 1 |
| 22 | Burhouse A, Rowland M, Niman H M, Abraham D, Collins E, Matthews H, Denney J, Ryland H (2015) *Coaching for recovery: a quality improvement project in mental healthcare*, BMJ Quality Improvement Reports, **4**, doi: 10.1136/bmjquality.u206576.w2641. | Y | Y | NHS Staff | Mixed methods | Students | 50 | UK | 2 |
| 23 | Central and North West London NHS Foundation Trust (2015) CNWL Recovery & Wellbeing College Annual Report April 2014 - July 2015. | N | Y | Recovery College staff | Mixed methods | Recovery College students, staff and supporters | 16 (Staff), 53 (service user and supporters) telephone survey, 1274 (evaluation forms) | UK | 1 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 24 | Kaminskiy E, Moore S (2015) *South Essex Recovery College Evaluation*, Cambridge: Anglia Ruskin University. | N | Y | Psychology Lecturers | Mixed methods | Students | 41 | UK | 1 |
| 25 | King T (2015) *An exploratory study of co-production in recovery colleges in the UK*, Sussex: University of Brighton. | N | Y | MSc Student | Quantitive | Recovery College staff | 23 | UK | 10 |
| 26 | Meddings S, McGregor J, Roeg W, Shepherd G (2015) *Recovery colleges: quality and outcomes*, Mental Health and Social Inclusion, **19**, 212-222. | Y | Y | NHS and Recovery College staff | Qualitative | Literature | N/A | UK | N/A |
| 27 | Gill K (2014) *Recovery Colleges. Co-Production in Action: The value of the lived experience in "Learning and Growth for Mental Health"*, Health Issues, **113**, 10-14. | N | Y | Researcher | Qualitative | Recovery College staff and students | 6 | Australia | 1 |
| 28 | McCaig M, McNay L, Marland G, Bradstreet S, Campbell J (2014) *Establishing a recovery college in a Scottish University, Mental Health and Social Inclusion*, **18**, 92-97. | Y | Y | Researchers and Recovery College staff | Qualitative (narrative account) | N/A | N/A | UK | 1 |
| 29 | McMahon J, Wallace N, Kelly J, Egan E (2014) *Recovery Education College: A Needs Analysis*, Limerick: University of Limerick. | N | Y | University researchers | Mixed methods | Service users, staff, carers, general public | 260 responded to survey, 20 in focus group, 8 in interviews and 7 in community consultations. | Ireland | 1 |
| 30 | 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**, 16-25. | Y | Y | NHS and Recovery College staff, community partners | Mixed methods | Recovery College Staff | 7 | UK | 1 |
| 31 | Meddings S, Guglietti S, Lambe H, Byrne D (2014) *Student perspectives: recovery college experience*, Mental Health and Social Inclusion, **18**, 142-150. | Y | Y | Recovery College and NHS staff | Qualitative | Students | 40 | UK | 1 |
| 32 | Rennison J, Skinner S, Bailey A (2014) *CNWL Recovery College Annual Report April 2013 - March 2014*, London: Central and North West London NHS Foundation Trust. | N | Y | Recovery College staff | Quantitative | Students | 44 (interviews)442 (feedback forms) | UK | 1 |
| 33 | Zucchelli F, Skinner S (2013) *Central and North West London NHS* | Y | N | Freelancer, NHS and | Qualitative | Students, Recovery College | N/A | UK | 1 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | *Foundation Trust's (CNWL) recovery college: the story so far…,* Mental Health and Social Inclusion, **17**, 183-189. | | | Recovery College staff | | and NHS staff | | | |
| 34 | Mind (2012) *Establishment of the Mind Recovery College*, Heidelberg: Mind Australia. | N | N? | ? | N/A | N/A | N/A | Australia | 1 |
| 35 | Perkins R, Repper J, Rinaldi M, Brown H (2012) *Recovery Colleges*, London: Implementing Recovery Through Organisational Change. | N | N | IMROC | N/A | N/A | N/A | UK | 2 (mentioned) |
| 36 | Rinaldi M, Morland M, Wybourn S (2012) *Annual Report 2011 – 2012 South West London Recovery College*, London, South West London and St George's Mental Health NHS Trust. | N | Y | NHS Staff | Quantitative | Students | 1,260 | UK | 1 |
| 37 | Rinaldi M, Suleman M (2012) *Care co-ordinators' attitudes to self-management and their experience of the use of the South West London Recovery College*, London: South West London and St George's Mental Health NHS Trust. | N | Y | NHS Staff | Quantatitve | Care-coordinators | 47 | UK | 1 |
| 38 | Rinaldi M, Wybourn S (2011) *The Recovery College Pilot in Merton and Sutton: longer term individual and service level outcomes*, London: South West London and St. Georges Mental Health NHS Trust. | N | Y | NHS Staff | Quantitative | Students | 174 | UK | 1 |
| 39 | Bourne, Meddings, Cooper, Locks & Whittington (2016) *An evaluation of service use outcomes in Sussex Recovery College*. Sussex NHS Trust. | N | Y | NHS Staff | Quantitative | Students | 199 (but varies per analysis) | UK | 2 |
| 40 | Bristow (2015) *An annual report of Lincoln Recovery College*. Lincolnshire Partnership NHS Foundation Trust. | N | | Recovery College staff | Mixed methods | Students | 154 | UK | 1 |
| 41 | Martina (2015) *Poetry for recovery: Peer trainer reflections at Sussex Recovery College.* Clinical Psychology Forum 268 (April). | Y | Y | Recovery College staff | Qualitative | Students | 8 | UK | 1 |
| 42 | SRC (2014) Solent Recovery College, Our first year – Outcomes. | N | | Recovery College staff | Mixed methods | Recovery College students and staff | 64 students, 17 trainers | UK | 1 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 43 | Barton (?) South West Yorkshire Partnership NHS Foundation Trust Recovery College, ppt. | N | N | Recovery College staff | N/A | N/A | N/A | UK | 1 |
| 44 | Sault, Garner and Gatherer (?), Southern Health Recovery College, ppt. | N | N | Recovery College staff and students | N/A | N/A | N/A | UK | 1 |

## Online Supplement 2

### Preliminary coding framework from document analysis and service user / carer workshop

**STAFF MECHANISMS OF ACTION**

1. Professional competence
    - 1.1 Working from theories of adult learning
        - 1.1.1 Co-production
    - 1.2 Taking professional responsibility to maintain boundaries and structure
2. Personal commitment
    - 2.1 Demonstrating a commitment to recovery

**STAFF OUTCOMES**

1. Attitudes and beliefs
    - 1.1 Perceptions of service users
    - 1.2 Motivation
2. Clinician-service user relationships
    - 1.1 Reciprocity in clinician-service-user relationships
    - 1.2 Clinician-service user collaboration
3. Learning
4. Distributed leadership
5. Wellbeing
    - 5.1 Peer trainers' recovery
    - 5.2 Peer trainers' sense of having 'something to offer'
    - 5.3 Peer trainers' confidence
    - 5.4 Peer trainers' self-esteem

**SERVICES MECHANISMS OF ACTION**

1. Challenging traditional models of mental health care
2. Learning from people with lived experience
3. Shifting the perception and enactment of power relations

**SERVICES OUTCOMES**

1. Culture, attitudes and beliefs
2. Models of care
    - 2.1 Education and recovery
    - 2.2 New jobs for people with lived experience

**SOCIETAL MECHANISMS OF ACTION**

1. Family and friends as students
2. Co-production with community organisations
3. Pathways to communities

**SOCIETAL OUTCOMES**

1. Communities as agents of change
2. Stigma and discrimination
3. Public health
4. Employment

**Online supplement 3**

**Final coding framework**

Participant responses shown in italics.
Harmful mechanisms and negative outcomes shown in red.

**Staff mechanisms**

The Equality and humanness code captured staff experience of a softening of traditional roles (e.g. service user, clinician):

> *Working this way with people I didn't think I had anything in common with before and people I wouldn't normally mix with, it really opened me up to, you know, that…they're all human beings, before doctors.* (Peer trainer #2)

> *You forget you're a social worker…you're just a person in a room learning about something that is important to you.* (Clinician and staff student #1)

This level environment set the stage for peers and non-peers to work collaboratively:

> *The peer-trainer and I had to sit down and write the course from scratch. Which was very eye-opening to the pair of us, about what approach we would both take, and what baggage we were both bringing to the table.* (Non-peer trainer #2)

> *You forget you're a social worker…you're just a person in a room learning about something that is important to you.* (Clinician and staff student #1)

Non-peer trainers sometimes struggled with co-production as a new way of working.

> *They [clinicians] struggle with what's the difference between a therapy group and a Recovery College course, if they both have the title of managing anxiety…Some of the feedback from peers has been, it's sometimes been a challenge when the professional has taken over, because they've run, like, you know, they've run a course in a certain way, not really, not getting the fidelity to the model of the Recovery College.* (NHS manager #1)

Equality can also be seen in the way staff work with students rather than delivering an intervention to them:

> *It's also beneficial for professionals coming to do it as well as service users because they learn to see service users in a slightly different light…They're not there to medicate or to solve. Which is probably different for them.* (Peer trainer #1)

The Empowering staff environment code captured how staff experience the RC environment as empowering:

> *I can remember leaving the first course thinking, for the first time in years, I feel as if I've done something that's really made a difference to people.* (Non-peer trainer #3)

Ongoing support and regular supervision are an important feature for peer trainers:

> *Being in an environment where they [peer trainers] are supported and supervised,*

*and their mental health issues are recognised and dealt with... In other organisations and especially corporate, you know, that would be something other organisations really struggle to maintain.* (Peer trainer #4)

The dynamic environment in which staff are regularly exposed to a variety of students and contribute to new course content is experienced as as contrast to traditional mental health services:

*It's quite fast moving and you do a term, and then you might do another course, and it's all quite new and you can bring in new courses, and it's always like changing and it's a lot of different people, and it just keeps people's motivation going... it's creative.* (Recovery College manager #2)

Finally, the environment is empowering for staff as their work carries a level of responsibility, although for some peer trainers this can be a negative experience:

*I don't know whether it's because of the responsibility that they have, because it comes with responsibility, doesn't it, being a trainer or co-facilitator...* (Community partner organisation #1)

*Some people [peers] couldn't, sort of, cope with it, weren't ready for that kind of level of responsibility.* (Peer trainer #4)

The Staff working style code captured the impact of interacting with students and delivering courses in particular ways, such as honesty about limits and sharing lived experience:

*Just be honest, as early as possible and start as you mean to go on and it doesn't mean I've always got it right, it's not all about getting it right... "this is what I can do and this is what I can't do."* (Peer trainer #2)

*And the way that they're [peer trainers] seen to have this knowledge that they're sharing with other people that they might not have realised was something that they could share with other people.* (Community partner organisation #1)

RC staff commitment to recovery principles, such as expressing belief in a students' ability to achieve their recovery goals, was spoken about in relation to peer trainers:

*I think how we communicate that [a student's goals] and the sense of belief we have in that, and the language that we use, I think that gives hope to that person.* (Recovery College manager #1)

Despite the centrality in RC guidance, only one participant noted that staff work from theories of adult learning:

*And it's about it being an educational approach, and actually teaching people rather than trying to treat people… You've got to have your lesson plans. And you've got to have your theories about adult learning... you've got to know that people learn in a different way.* (Recovery College manager #2)

The Staff attend courses as students code captured a further mechanism:

*Because not everybody that comes are people who have got mental illness*

*themselves, some of them are staff who work in other organisations and who want to know a bit more about it.* (Community partner organisation #1)

One participant suggested that it is insufficiently clear that courses are open to staff:

*She said staff are not aware enough that they can go on them.* (NHS clinician and staff student #1)

**Staff outcomes**

The Professional Practice code captured how non-peer staff change the way they work with and relate to service users in their clinical practice:

*I've learned so much about myself really, about how I deliver or how I teach can be changed to suit the audience, and to be less clinical, less stigmatising really, and, sort of, diagnose-y…I never realised how clinical I am in terms of the way that I describe things.* (NHS manager #1)

This practice change was underpinned by changed assumptions about how well service users are able to learn and recover:

*It opened up my eyes... I imagined what would happen is there'd be a class of people that'd be like this, just, they'd be slumped over. They'd be nervous they wouldn't want to put their hand up, they wouldn't want to ask questions. And it was the complete opposite.* (Non-peer trainer #3)

*I think it has a massive effect on the clinicians that peers teach with as well... It shows that you can move away from just a user of mental health service into more, and you can even use your experience of that to teach other people... I just can't see how it wouldn't change people's perceptions really.* (Recovery College manager #2)

*I think as well what it really highlighted for me, because it was a real range of people with psychosis in that room, very different presentations, you know, and I think that came back with me... it's broken up the diagnosis, if that makes sense. That psychosis can be in many different ways.* (Clinician and staff student #1)

Peer and non-peer staff also experienced an increase in Passion And Motivation in their work:

*It is the most motivated place I've ever worked, in terms of... there's something about it, people just love it... it's always like changing and it's a lot of different people, and it just keeps people's motivation going.* (Recovery College manager #2)

*There was the sense of wanting something, there has to be something better than this for me personally as a clinician... it [Recovery College] kept me fresh, it opened up my eyes again, something to look forward to, clinically I was getting something out of it.* (Non-peer trainer #3)

Clinicians gain a new appreciation for co-production and actively seek to work alongside people with lived experience more in their routine work:

*I will think, everything I do now, let's look at about how we can co-produce this... God, my mindset has absolutely shifted, to the point now I wouldn't even dream of doing*

*policy, or anything without it being ratified or going through a peer, in any shape or form.* (NHS manager #1)

Reduction in stigmatising or clinical Language was also identified:

*I've changed my language very much around mental health. I said something about "committing suicide" and one of the peers said "You can't commit suicide, it's not a crime. You shouldn't use that term". And so I never use that term now.* (Recovery College manager #2)

*The language, the stigma associated. I never realised how clinical I am in terms of the way that I describe things.* (NHS manager #1)

The Wellbeing code captured the positive impact on the recovery and wellbeing of peers:

*I see the same for the peer workers, the peer trainers, is that where they were so dark, so horrible, it's that springboard out into the light, whatever their light might be.* (Non-peer trainer #2)

*For me, the Recovery College... put a whole load of jigsaw puzzle pieces together for me, when I was trying to recover, trying to manage, trying to not be isolated.* (Peer trainer #4)

Career progression occurred for peers through training and acquiring new skills:

*A lot of those first cohort of peers have gone on to work. And I think that's what peer training is, it's really exciting and for the individual that's a stepping stone to new employment opportunities.* (NHS manager #1)

*Several of them [peer trainers] are now peer support workers. We've got one that's now an occupational health technician. Several of them are looking at different possible career pathways.* (Peer trainer #4)

Peers experienced increased confidence, empowerment, self-esteem and an appreciation of their strengths:

*A lot of the peers are just so much more empowered in their own lives, I think, and just got that extra sense of doing something and being something, of, you know, at stake in society... Because the peer trainer role grew my confidence.* (Peer trainer #4)

Peers also obtained recovery-enhancing knowledge and skills through shared learning with students and other trainers:

*You're starting to re-narrate your mental health issues. You're turning them into opportunities, they're not issues... And learning off people, you know, so I've got tips last year from another peer trainer when I was having a series of panic attacks, you know, some tips from them, some empathy from them, some learning from them.* (Peer trainer #4)

Negative impacts on peers' wellbeing were also sometimes identified, both through overwhelming demands and the potential for exploitation:

> *Some of the peer trainers are quite fragile... every now and then something will trigger an adverse reaction… And how we ensure that, you know, what is a peer? That we're not using people as cheap labour, that we're not putting people in situations where they're unsafe, because we just haven't got enough clinicians on the ground.* (Commissioner #1)

Non-peer staff wellbeing also improved, through slowing down and talking more openly about their own wellbeing:

> *And I think that's what the peers bring to everything that I've been through with the Recovery College and with my role, is this "Why we working so hard, why didn't you do this, why aren't you slowing down, why aren't you looking after yourself?", you go "Oh yeah". And also they give us, as professionals, permission to say it's OK to not be OK.* (Non-peer trainer #2)

> *Without it [working at the Recovery College] I would've been even more sort of fed up and stressed.* (Non-peer trainer #3)

There was ambivalence about how clinicians with lived experience are viewed:

> *Because I can have lived experience, but it's diminished in value because I'm also a professional...I am always perceived as the person with book knowledge and not always perceived as the person with the experiential knowledge.* (Non-peer trainer #2)

**Services mechanisms of action**

The Degree of integration with other services code captured how many RCs develop in isolation, with little recognition or emotional investment from the host organisation:

> *I don't think anybody particularly noticed it [the Recovery College]... My manager was really good and I'd got a good relationship with her and she let me come here. I think there's been other people that have done courses for a bit but then have been dragged back, "It's enough, we need you back here".* (Non-peer trainer #3)

The positive risk-taking encouraged in RCs can appear incompatible with the risk aversion of the wider organisation, increasing the distance between the RC and its host organisation:

> *I think the Trust has been reluctant…to actually open up and take risks... and as all that's going on you've got this little bubble here, this little Recovery College, which is completely opposite to all of that sort of ethos, going on. And I suppose for the Trust it's been a little bit of a, it's good to have a little thing on the side isn't it, we can say "Look we're recovery-based" [laughs]. But actually if you look at the whole service, it's not really been like that.* (Non-peer trainer #3)

Organisational resistance to fully integrating with the RC was linked to a general resistance to change, such as hierarchical and bureaucratic processes making change difficult and time-consuming:

> *We're a bit like the Titanic, it's really - not that we're sinking - but trying to turn it around, it's a juggernaut, a big large bureaucratic organisation that employs over 5000 people. It's difficult to effect that change, and I think what we're doing, we're trying to challenge some of that traditional method which has been very 'medical model'.* (NHS manager #1)

By contrast, one participant highlighted the close integration between their RC and host organisation:

> *From the strategic level, we've got the Recovery College deeply inserted into the clinical strategy as one of the core delivery methods for opportunities.* (Peer trainer #4)

The Challenging traditional models of mental healthcare code indicated that recovery-focused values call into question the model used in wider services:

> *So that's the challenge to the traditional psychiatric medical model, which is still there in every single team. And so there's a conflict in every team that goes on around the recovery model and the medical model. I think the Recovery College has helped but it's been seen as a challenge.* (NHS manager #1)

Positive risk-taking was a specific point of difference:

> *And I've been slightly anxious about them coming and thinking "Oh is this person going to be safe?"... And the very fact that you don't do that [risk assessment], the very fact that they're seen as students and not service users... That seems, in my opinion, that seems to in some way have been a block against risk getting out of hand.* (Non-peer trainer #3)

The Opportunism and image management code relates to the social desirability for organisations of being seen to have a RC. It was suggested that organisations open RCs to elevate their status:

> *Traditionally, [the Trust] has always prioritised its esteem and reputation over the wellbeing of the people entrusted to it. It's undeniable that [the Trust] has ticked a big box in having a Recovery College.* (Non-peer trainer #1)

> *Anecdotally I think it's because they [the Trust] were going for Foundation status... And also because there was a near neighbour which already had a college so they would have been very much aware of that, and I think that got good publicity.* (Commissioner #3)

The Strategic partnerships with external organisations code reflected that some RCs work in partnership with both statutory and non-statutory organisations. Despite tensions in funding priorities, this enabled shared prioritisation of mental health service development and effective allocation of human and financial resources:

> *If you had less stigma and were open to mental illness you would have to fight less hard in commissioning settings to get equal funding and attention and so on for mental illness... I could see the public and mental health potential in it, but when you know you've got a politician behind it, for different reasons, you have to sort of, your funding has to be approved.* (Commissioner #3)

Finally, the Leadership code captured that RCs are drivers of change in the wider mental health and social care system because of their strong, passionate leadership. The importance of "champions" who speak out at a strategic level was noted:

> *If you're looking at managing change and leadership, you need really good leadership at different levels of an organisation. And I think we've had that, key people. It's not just about one person... There's lots of other key people around, championing that.* (NHS manager #1)

**Services outcomes**

The Co-production code was the most frequently-coded system outcome:

> *Everything we do is in line with peers. And I think, changing services, I think the cultural effect of the Recovery College on this organisation has been a proliferation of co-production.* (NHS manager #1)

The Peer workforce code captured how the development of peer roles across services was seen as an outcome, associated with lowered discriminatory assumptions about the abilities of workers with lived experience and more willingness to make workplace adjustments:

> *We suddenly had a peer workforce. The original cohort was 11. Then there was 24, and we're just, you know, it's gone up to nearly 28, 29 now peer trainers … it means the [Trust] can draw, at any point, those peers into other roles, not just peer training roles.* (NHS manager #1)

> *And I think a penny dropped, that actually "Oh OK", his assumption was that people [peers] would be coming and going... I just think there are still assumptions within any organisation that someone who's got mental health challenges is going to be off sick all the time or is going to leave... I think it's about showing people that the lived experience is as valuable as anything else really. And yes sometimes people might need to take some time off, or might need a bit of extra support... that is OK.* (Recovery College manager #2)

With this outcome comes a risk that organisations begin to exploit peer trainers without offering them substantive posts:

> *It's gone up to nearly 28, 29 now peer trainers, and most of those are on bank [occasional employment].* (NHS manager #1)

The Service development code was identified by many participants, who indicated that Recovery Colleges influence wider services:

> *We're using peer trainers and peer support workers in new adventures like the 'working together' groups, which are solution-focused groups working with the people participation team, who have drawn from the experience of the Recovery College.* (Peer trainer #4)

RCs are viewed as a resource for the wider organisation to draw inspiration and expertise from:

> *Everyone in mental health services is aware of the Recovery College, it comes up in every meeting in every forum that I've been to. They talk about making links with them, they talk about contacting them for their feedback on other things, see what they're doing, see if they can borrow some of their methods, you know, I think it's very influential.* (Service user student #1)

This leads to a shift towards more recovery-oriented practice:

> *I think it [the Recovery College] opens up some opportunities and a different way of thinking about our whole approach... If you didn't have the Recovery College here they [psychiatrists] might still struggle in their day-to-day work to see beyond the medical model potentially.* (Commissioner #3)

RCs can provide support to people waiting to access other services:

> *I found it a really, for me it felt like a tool that I could use or offer, at least, make suggestions for signposting. Because I think there's some gaps in services. It felt like it filled a gap, to me.* (NHS Clinician #2)

They also strengthen relationships with community organisations:

> *We forged some very close relationships, so that when it came to changing services, when we got commissioning money for Tier 2 services, it was like, "Oh we can just phone up, I know the Chief Executive of [national voluntary organisation] and I'm sure they'd be happy to do that".* (NHS manager #1)

The fourth outcome of Attitudes and beliefs captures the potential of RCs to change attitudes held in mental health services, away from a containing and treating focus towards a greater belief and use of language around people's assets and ability to help themselves:

> *I'm not sure we're there to the point where all of that [culture] has been challenged and all the culture, attitudes and beliefs have changed. But it [the Recovery College] is a massive vehicle to do it, I think.* (Recovery College manager #2)

> *Adult services, the language and policy now is around you must work with whatever the language is, co-production, peer participation, peer mentoring. I think the language has changed nationally, as well as what we've done locally…The Trust now talk all the time, in their clinical strategy, "We need to work with our third sector organisations". That wasn't around.* (NHS manager #1)

Some staff linked the separation of the Recovery College from its host organisation with a view that their influence on other services is limited.:

> *I think people are very willing to learn from the Recovery College as a model, but I think there would be very wide spread resistance at it becoming a dominant way of delivering services. I think it's because of the tendency everywhere to fall to the status quo.* (Commissioner #2)

> *... the fact that it's so easy to get somebody here [the Recovery College] should be advertised more to the Community Mental Health Teams, because I'm not sure how people realise that.* (Non-peer trainer #3)

The final proposed outcome for systems was Cost and resource savings, due to the less labour-intensive group format of classes and to students' increased self-management skills, improved discharge rate, and reduced contact with services:

> *Actually by getting someone to a Recovery College, we know from some of the research that's been done, it's much more cost-effective to do things as a group than*

*do it individually…people should contact secondary mental health services less because of it.* (NHS manager #1)

**Societal mechanisms of action**

The most frequently coded mechanism was Working with community organisations to co-produce courses. This enabled community organisations to engage with students they might not otherwise have worked with:

*The Recovery College tends to work with slightly different groups of people. So it's really helpful to be able to do what we do with a different group of people... So I think we've done now seven or eight Recovery College courses, so quite a few. And it does seem to work really well..* (Community partner organisation #3)

The other mechanism of action at the societal level was public involvement, for example through public-facing marketing materials and through members of the public attending courses, regardless of whether they or someone they care for were experiencing mental health difficulties:

*We use traditional forms of communication, which is through the prospectus, online, people hear about it through social media.* (NHS manager #1)

*Not everybody that comes has a mental illness themselves and some of the people that came, came via the carers organisation. And they were carers for people not necessarily with a mental health problem, some of them with learning disabilities, some of them with physical disabilities.* (Community partner organisation #1)

**Societal outcomes**

The most frequently reported impact of RCs was on Public attitudes and awareness, by reducing negative assumptions about people with mental health problems:

*I can see the Recovery College as being part of an anti-stigma agenda as well...if we can reduce stigma, that in itself has a population benefit, i.e. it reduces the burden on individual patients and also opens up conversations amongst all different parts of society, including amongst commissioners.* (Commissioner #3)

Recovery Colleges foster social inclusion by increasing friendships, integration into the community and shared mental health experiences:

*It's also just about offering friendship, offering community involvement, offering somewhere to go that feels safe, its offering community and purpose and being involved in something... it allows people to actually come and just be involved a bit more in the community.* (Community partner organisation #4)

*I think people, when they're in that kind of situation they discover things about themselves that make them realise they're not that far away from the people that are categorised as "patients".* (Commissioner #2)

However, public awareness of RCs can be low:

*A lot of the time when I go places people say "Well I've never heard of that [the Recovery College], it's fantastic". So we're not reaching places that maybe we could do.* (NHS manager #1)

Where engagement does happen, public mental health awareness is increased:

> *There are lots of organisations like the National Trust, the Wildlife Trusts, the National Parks, who are really understanding that they have this fabulous resource in terms of nature, it has a great effect on wellbeing, and somehow they have to offer those resources out to more people that might be struggling with mental health.* (Community partner organisation #3)

The Benefits for community organisations code arises from working with RCs through increased public access to their services and increased co-production in their own work:

> *I think also one of the things that's been really helpful is that sort of referral between the two organisations. So, quite often what will happen is people go to Recovery College first, do the Recovery College course, and then want to kind of progress onto something else, so then will come from that onto the [name of organisation] course.* (Community partner organisation #3)

> *Because if they [community partner] see how well it [co-production] works, and that it does work, they're more likely to go back and think "Oh OK that's how we should do things again" really.* (Recovery College Manager #2)

The Impact on friends, family and carers code captures how they change in how they offer support, and may also experience improvements in their own quality of life through witnessing their loved ones improve after attending Recovery College courses or through attending courses themselves:

> *The family and supporters found it really helpful to see a different perspective about how to care for their loved one or someone they were supporting.* (NHS manager #1)

> *If…RC courses help people to, you know, on the road to recovery, the knock-on effect of that on people's friends and family is probably massive.* (Community partner organisation #3)

Finally, the Employment and volunteering code captures how communities benefit economically through increased occupational engagement from students after attending courses:

> *They're little seeds but if you actually look at how they ripple out into society... You have someone who is isolated and disengaged with society, and then is able to contribute by volunteering or is interested to go on and train in something or do a course or do something else, even get back into work.* (Community partner organisation #3)