Embedding a recovery college in a psychiatry organisation promotes its implementation: A Swedish qualitative case study

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Submitted to: Journal of Participatory Medicine
on: December 28, 2023

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Abstract

Background: Recovery colleges are user-led educational interventions aiming at empowering people with mental health issues and promote recovery through peer-learning. Despite the increasing interest in recovery colleges in recent years and the demonstrated beneficial effects for users, there is limited research addressing aspects that influence their implementation. This knowledge is necessary for the successful integration of such interventions in various contexts.

Objective: The aim of this study is to explore factors that influence the implementation of a recovery college embedded within a Swedish psychiatric organization.

Methods: A qualitative case study based on semi-structured interviews with eight course participants, four course leaders, and four clinical staff of a recovery college was conducted. The transcripts were analyzed with a conventional content analysis.

Results: The findings highlight key areas that either hinder or promote the successful implementation of the recovery college. These areas encompassed, recruitment, resources, staff attitudes, and ways of organizing courses. Each area appears both as facilitators and barriers, demonstrating opposite conditions.

Conclusions: Allocating dedicated resources, engaging individuals with user-experience as organizers who are willing to share their personal experience, having an open-door policy, creating an open space for participants to share, and offering practical advice and written material felt useful, create favourable conditions for a recovery college to reach is goals of empowering psychiatry service users.

(JMIR Preprints 28/12/2023:55882)
DOI: https://doi.org/10.2196/preprints.55882

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Recovery colleges are service user-led educational interventions aiming at empowering people with mental health issues and promote recovery through peer-learning. Despite the increasing interest in recovery colleges in recent years and the demonstrated beneficial effects for users, there is limited research addressing aspects that influence their implementation. This knowledge is necessary for the successful integration of such interventions in various contexts.

Objective:

The aim of this study is to explore factors that influence the implementation of a recovery college embedded within a Swedish psychiatry organisation.

Methods:

A qualitative case study of recovery college based on semi-structured interviews with eight course participants, four course leaders, and four clinical staff was conducted. The transcripts were scrutinised with conventional content analysis and the interpretation of results was guided by the Consolidated Framework for Implementation Research.

Results:

The findings highlight key areas that either hinder or promote the successful implementation of the recovery college. These areas included *recruitment, resources, staff attitudes, and ways of organising courses*. Each area has elements that appear both as facilitators and barriers, demonstrating the duality of conditions.

Conclusions:

Allocating dedicated resources, engaging individuals with service user-experience as organisers who are willing to share their personal experience, having an open-door policy, creating an open space for participants to share, and offering practical advice and written material felt useful, create favourable conditions for a recovery college to reach is goals of empowering psychiatry service users.

Key words

Mental health, educational intervention, recovery college, implementation research approach, qualitative research, co-production

Introduction

Many mental health service users have engaged in self-care with the aim of taking control over their lives despite disease, as well as turning to peer-support. This started in the US as a mental health consumer movement in the 1970's. In an "emerging issues" paper Davidson (2016) discusses how this movement has been supported by changes in US legislation from the 1990's onwards. He refers to longitudinal studies of schizophrenia patients performed in the 1970's and 1980's that changed the previously pessimistic view on psychiatric disorders (Strauss et al 1977, Harding et al 1987). This was well in line with the personal experience of people that they were, despite a psychiatric diagnosis, able to lead meaningful and productive lives. He also claims that those studies showed that the capacity of patients to recover fully or learn to manage their condition in many instances developed outside formal treatment settings.

Perkins et al (2012) differentiate this patient-driven self-management activity from professional psychiatric care by referring to those as "educational" vs. "therapeutic approaches". Instead of focusing on problems and dysfunctions, and labelling all activities as therapies, the recovery movement supports people to identify and develop their talent and skills, explore their possibilities, and focus on achieving ambitions and goals. It has, consequently, also been defined as an "assets-based" approach, aiming at developing the "recovery capital" of patients, defined as "the array of social, psychological and cultural networks beyond professional inputs" (Burns 2010).

"Recovery colleges" are such educational activities that have proliferated in the UK. A network titled "Implementing Recovery through Organisational Change" (ImROC) coordinates about 40 recovery colleges that engage over 500 peer workers promoting learning and self-management as core practices among mental health patients (www.imroc.org). Recovery colleges are typically led by persons with lived experience as service users and focus on sharing experience, support for coping and skills training.

The interest in recovery colleges has increased over the years, more colleges have been established and the number of reports on their outcomes grows. A recent systematic review concluded that “Recovery college attendance was associated with high satisfaction among participants, attainment of recovery goals, changes in service providers’ practice, and reductions in service use and cost” (Thériault et al 2020). To attend a recovery college was described by participants as being useful and supporting recovery, leading to a decrease in service use (Meddings et al 2015). Another study reports that wellbeing and personal resources were strengthened, user satisfaction increased as service provided was perceived as accepting and enabling - in addition participants felt a greater sense of hope, confidence, and higher aspirations (Ebrahim et al 2018). In focus group interviews recovery college participants expressed that they had experienced a positive impact on their lives and seen benefits to the organisation brought by the college (Zabel et al 2016).

A systematic literature review analysed outcomes of recovery college activities on mental health staff, on mental health services and the society at large (Crowther et al 2018). Mental health clinical staff who participated in recovery colleges valued collaboration with service users, and, as a result, gained a different perception of those and felt more passion and higher job motivation. Within mental health organisations, recovery college activities provided staff with a learning environment to practice co-production with users. Recovery colleges involve agencies in the community and their staff in collaboration with service users which has a positive effect on staff attitudes and public opinion (Crowther et al 2019).

Some impact studies have included process evaluations with information on programme content and resources employed. Those tend to focus on improvement opportunities, like standardising course processes and planning for longer courses Wilson et al 2019). Hall et al (2018) represent one group of a few researchers addressing the implementation of a recovery college. They found “delays in the development of some key policies and procedures, including the enrolment and attendance information, standardization of evaluation measures and course standardization”. Reasons

for these delays were lack of resources, funding and staffing, staff turnover and less defined staff roles. Some staff felt uncertain about co-producing with persons with lived experience, and the quality of external expert input. Slade et al. (2014) found similar attitudinal problems among staff, characterising those as “abuses of recovery colleges”. Staff might feel that recovery colleges are a fad, that those would not benefit their patients, and that psychiatry services would be sufficient to address their problems.

In summary, these studies on the outcomes of recovery college activities show high satisfaction among participants experiencing a greater sense of hope, confidence, strengthened personal resources and a positive impact on their lives in general. Finally, participants had reduced their use of formal services. Mental health professionals with an experience of recovery colleges valued collaboration with service users and reported, as a result, feeling more passion and higher job motivation. The collaboration between recovery colleges and agencies in the community had a positive effect on the staff of those agencies and public opinion. Challenges were also reported. Lack of resources, funding and staff attitudes would delay the launch of a recovery college. Some staff felt that the activity would not benefit their patients beyond that of formal psychiatry services.

When setting up a recovery college prospects for success would be enhanced by a clear conceptualisation of the college, an integration between the college and the host organization and attention paid to the power imbalance between providers and patients (Ali et al 2022). These observations refer mostly the design of the educational activity, whereas information on the way in which plans have been carried out and adjusted to fit local conditions and contexts are lacking. Such an approach is referred to as “implementation“, which preferably should be studied with an “implementation research approach” (Peters et al 2013). Hence, implementation includes not just the introduction of an intervention but also the continuous adaptation and optimisation of it within the organisational context.

Giving the scant literature and the importance of understanding the context, we set out to specifically study the *implementation* of a recovery college, which is embedded in a psychiatry organisation. Elsewhere, Recovery Colleges are typically free-standing centres. We took advantage of the fact that we had access to one recovery college at a psychiatry clinic, called “Patient School”, in Region Stockholm, Sweden. We have recently analysed the value of this Patient School, as described elsewhere (by [removed for peer-review], forthcoming). Hence, the aim of this study is to explore factors that influence the implementation of the Patient School within this psychiatry organisation.

Methods

Study design

This is a qualitative inductive study based on semi-structured interviews, conducted using a co-produced approach (Sage Handbook 2017, Lin et al 2023). The research team includes persons with formal experience of research (health care professionals and other academically trained - see affiliations), and also ones with lived experience of being a patient in mental health care, and presently working in the psychiatry organisation. The team of authors co-created all different aspects of the research process, including reflexive discussions on how team members’ different perspectives have affected the research process. The COREQ guidelines (see appendix A) have been followed to support the transparency and quality of this research (Tong et al 2007). To strengthen the focus on the implementation process the analysis and the interpretation of the data was guided by the updated Consolidated Framework for Implementation Research framework, as proposed by Damschroeder et al. (2022).

Context

The psychiatry organisation provides both in-patient and outpatient services to the Region

Stockholm population and is part of its public healthcare. It has consistently led efforts in fostering user participation and organising user-centric initiatives within the mental health sector of this region. Since 2007, the psychiatry organisation has appointed dedicated "user-involvement coordinators" on a full-time basis. By 2016, the organisation expanded its approach by incorporating peer-support workers, known as "staff with user experience", who serve as mentors for patients in psychiatry units. User-involvement coordinators conduct regular surveys among users to gather insights and relay this information to the psychiatry organisation's management. Additionally, a user-involvement coordinator holds a position in the organisation’s Patient Safety Group and presides over the User Council, which includes members from patient organisations and the management team. The founders of the Patient School were working within the organisation as user-involvement coordinators or staff with user experience. The Patient School was established in 2018 by the user-involvement coordinators and offered initially to outpatient users. The clinical manager, who the lead user-involvement coordinator reported to, endorsed the plan and anchored it with the full senior management team of the organisation. The Patient School gatherings take place in psychiatry care facilities with the support of the management and with professional staff contributing.

As guiding principles for the Patient School, they agreed upon (i) promoting recovery; (ii) placing the activity in facilities within the psychiatry organisation with the support of its leadership; (iii) choosing employed user-involvement coordinators and staff with user experience as coordinators; and (iv) whilst encouraging sharing of personal experience, avoiding suggesting those as generalisable recommendations.

Before launching the first Patient School programme, the course leaders had visited recovery colleges in England, acquiring inspiration from that experience. They then formed a working group to make sure they all had the same vision for the programme. All leaders were present at every meeting during the first round of Patient School, so that they would all teach the course the same way. After that, the work was divided, and leaders were assigned sessions with specific themes so

that not all had to be present every time.

As previously described in (by [removed for peer-review], forthcoming) the Patient School was founded in 2018 for both inpatient and outpatient units. However, information about the Patient School was originally circulated at outpatient departments (ambulatory mental health centres). All participants so far have been recruited this way.

In total 12 courses were given with close to 70 course participants. The Patient School consists of a series of five workshops given over five weeks covering the following themes: Psychiatry – how does it work?; Recovery –what is helpful?; Other resources in society; Relations and disclosure; and Personal tools. The course leaders invited, to each workshop, health care personnel from the psychiatry organisation or researchers to act as co-leaders and substance matter experts.

The study is part of the “Patients in the driver’s seat” partnership research program, situated at [removed for peer-review] exploring patient-driven innovations to promote self-care and co-care [removed for peer-review].

The choice of themes to include in the course curriculum was based on views expressed by psychiatry service users in “Patient forums”, organised by the user-involvement coordinators planning the Patient School. Some of those were related to “patient competence”, i.e. knowledge about the healthcare system, laws and regulations needed to be able to “navigate the system”. Patient School participants (service users) were asked for feedback, both orally and in surveys, and the content was adjusted accordingly. Participants in previous courses were engaged to be mentors to new participants and participated alongside those. These mentors shared their observations and gave useful feedback.

Participant recruitment

The data used for this study was gathered as part of a larger research project as described in (by

[removed for peer-review], forthcoming). Participants in the Patient School who had provided contact information during or after completing the school, in total 45, were invited by [removed for peer-review] to participate. Seven clinical staff who acted as experts as well as six course leaders (user-involvement coordinators and staff with user experience) were also sent invitations. Apart from one who is a co-author with user-experience by [removed for peer-review], no previous relationships with by [removed for peer-review] were established before the commencement of the study. by [removed for peer-review] was introduced as a researcher interested in exploring participants' views about the Patient School. The timeline of respondent recruitment is presented in appendix b.

Ethical approval has been granted by [removed for peer-review].

Data collection

A researcher trained in qualitative methodology and interview technique was responsible for developing a semi structural interview guide, and it was discussed, revised and received approval from the entire team. The interviews were conducted over the telephone by the same researcher [removed for peer-review] from her office. The interviews were recorded and transcribed verbatim. The respondents had received written information in advance and were able to ask questions before the interview started. An interview guide was designed in discussions within the research team including members who had been involved as course organisers. Their experience was important to identify different items of the implementation process that could be used in follow-up questions. Yet the interviews started with open-ended questions such as "according to you, what is needed for the Patient School to be carried out?", and probes like "can you tell me more about that". The data collection stopped when no more aspects connected to the study aims were identified, i.e when data saturation was reached.

Data analysis

The transcripts were subjected to conventional content analysis using an inductive approach (Hsieh and Shannon 2005). For this current manuscript, interview data were analysed with the particular focus on aspects of implementing the Patient School. First, [removed for peer-review] read through all transcripts several times to reach immersion and formulated meaning units to cover all sections of the text that responded to the aim and defined two main themes, barriers and facilitators. Barriers refer to obstacles and difficulties when organising courses, facilitators conditions that had made implementation easier or promoted perceived successes. [removed for peer-review] read five transcripts to verify the preliminary categorisation.

The selected meaning units were checked against the original transcript, labelled, grouped and posted on a MIRO dashboard by [removed for peer-review]. [removed for peer-review] participated in four analysis workshops that started with all participants reading the meaning units in silence, making notes on their first impressions, thoughts, and initial analysis. The preliminary labelling and categorisation were discussed in the full team, and agreement was reached on defining sub-categories. All authors reviewed initial findings and suggested revisions until consensus was reached. [removed for peer-review] then returned to the full data related to the selected meaning units to select representative citations. To validate those [removed for peer-review] read all the transcripts and confirmed the preliminary analysis. In this way data analysis was performed by all team members participating, while also protecting the integrity of the interviewees. As it was felt that member checking would have run the equal risk of individual interviewees being identified the procedure was not performed.

[removed for peer-review] was responsible for manuscript writing and composition. She drafted and revised the manuscript based on critical input from the other authors. Of crucial importance were user involvement coordinator members' comments which guided the contextual interpretation. All authors approved the final manuscript.

Results

Sixteen individual interviews were conducted during March-May 2021, (lasting between 25-75 min) with eight course participants, four course leaders, and four clinical staff who had participated in the Patient School as invited experts.

Table 1. Participants characteristics (n=16)

Participants of the Patient School		Participants, n
Course leaders		4
Clinical staff		4
Course participants		8

The findings highlight key areas that either hinder (barriers) or promote (facilitate) the successful implementation of the Patient School within the psychiatry organisation. These areas encompassed *recruitment, resources, staff attitudes, and ways of organising courses*. Findings are structured around these distinctive sub-themes. Each subtheme appears both as facilitators and barriers, demonstrating opposite conditions. Our comprehensive summary of the findings is described in Table 2.

Table 2. Summary of barriers and facilitators for the implementation of the Patient School based on interviews with course leaders, participants, and staff and course documents.

BARRIERS	FACILITATORS
- Recruitment • Lack of contacts with fellow service users • Lack of knowledge and understanding of the Patient School and its benefits among clinical staff - Resources • Patient School not included in the reimbursement system • Focus on service production, less time for staff to support Patient School • Lack of dedicated venue - Negative attitude among staff • Negative stance towards staff with	+ Recruitment • Everybody can join the Patient School • Active information to patients from staff + Resources • User-involvement coordinators and staff with user experience as course leaders

user experience and patient involvement • Change resistance – fear of heavier workload • "Wrong to teach a person to be a patient"	+ Positive attitude among staff • Patient satisfaction and perceived value of Patient School increases staff motivation to support Patient School
- Ways of organising course • Course leaders spending too much time on describing own experience left little space for participants • Some participants dominated too much • Some experts not appreciated by participants	+ Ways of organising course • Course leaders sharing own experience encouraged participants • Moderator giving everybody space • Participant feedback paid attention to • "Open door policy" (everybody is welcome) • Appreciated course material

Recruitment

Recruitment barriers for the Patient School were primarily attributed to limited contacts between patients and staff with user experience as well as user-involvement coordinators and inadequate information dissemination by staff. The staff were described to have an essential role in recruiting patients and conveying the value of the Patient School. Participants acknowledged that not

all patients had the opportunity to meet with staff with user experience and user-involvement coordinators directly, highlighting the importance of regular staff interactions with patients to disseminate information about Patient School and assist in recruitment efforts.

> *[In order for the patient school to be implemented, it is necessary] that [staff] want to participate, of course. Participate both with us and to help get information out so that people will be interested in it. So a collaboration is required*
>
> *(Interviewee #10)*

Ensuring that information about Patient School was available in wards and outpatient departments was described to be essential for successful recruitment. Although written materials were accessible in the clinics, participants viewed verbal reminders by staff as a necessary complement. However, the lack of active information about Patient School to patients from staff was described as a barrier by several participants. One staff interviewee explained that although reminding patients about Patient School would be helpful, it was easily forgotten about.

Some participants highlighted a lack of knowledge and understanding about Patient School among other staff. Interviewed staff described uncertainty about its structure and a lack of adequate information about how to provide patients with information about Patient School. Consequently, this led to feelings of insecurity when discussing the Patient School with patients.

The lack of an information channel about the Patient School was believed to contribute to a low understanding of Patient School among staff. Course leaders believed that it was difficult to spread information about Patient School to staff, and that it would have been valuable if information of Patient School benefits would have been shared with them. They expressed concern that patients who did not have the opportunity to meet with a user-involvement coordinator or staff with user experience might miss out on being informed about Patient School.

What can be an obstacle, then, is... that they, patients, have not met us, and are not informed by staff, i.e. their contacts at outpatient care, that the Patient School exists (Interviewee #3)

Recruitment was facilitated by adopting an inclusive approach, wherein all outpatients at the clinic that were willing and capable of participating in structured group events were welcomed to participate. It was also seen as a future enable factor to further spread the Patient School across all clinics in the region. That was desired by both staff and course leaders and could help to both increase the size of groups that were felt to be too small and minimise waiting lists that sometimes also occurred. It was also believed that if patients from other clinics were recruited it would help spread the word about Patient School. However, some interviewed staff raised concerns about mixing participants from different stages of recovery at the same sessions. They believed that there was a risk that people who had progressed on their path to recovery might have a backlash. This was confirmed by one staff:

Those who leads it [the Patient School] should have knowledge about whether there's a participant there who if something comes up that makes them feel bad, or triggers a flashback…that they can handle it[…] I think that whoever it was that was leading it, was very receptive to how people were feeling and how they reacted to what was said […] It's important to have the right person leading it[…](Interviewee #12)

Some participants made suggestions for the future improvement of the Patient School and expressed appreciation for the attentiveness of the course leaders to their feedback. For instance, a proposal was made to link participants' care plan with the course programme, which could create added value. Another proposal was to involve former participants to visit the Patient School, share

their experiences, and aid course leaders. Those “alumni” would shadow a course leader for some time to learn the dynamics of the Patient School and afterwards contribute as assistants of a course leader.

Resources

The success of Patient School was described as relying on essential resources, including the availability of user-involvement coordinators and staff with user experience, time, suitable venues, and funding. To Patient School in the regional healthcare reimbursement system was seen as the most important promoting factor, and if it was not, Patient School would not be able to evolve, yet alone survive. The absence of Patient School from the reimbursement system was thus highlighted as a significant barrier to its implementation.

> *But I think the priority would probably be to try to approach the clients or those who manage that part, and see if there is any order, some type of compensation we can get as a business, to hold the Patient School. Because I think it's more essential for us to survive (Interviewee #7)*

Participating course leaders described that with ear-marked funding more course leaders could be hired which would increase the number of sessions, lecturers with care provision commitments could be recruited, and a spread of Patient School across clinics would be possible. Another improvement would be to include Patient School education as a service to be reimbursed, in parallel with clinical services. The lack of these preconditions contributed to an undersupply and a long waiting list for participants to join Patient School at the clinic.

Participating course leaders emphasised that, at present, Patient School is held in the clinic’s

facilities and the venue must be booked in competition with other activities. Course leaders stressed the need for improved access to clinic facilities, of which some could be specifically dedicated to Patient School. When requesting the venue, course leaders were sometimes met with resistance, which was seen as a direct effect of Patient School not being a part of the reimbursement system. Patient School competes with other initiatives that generate income to the clinic which often were given first access.

Course leaders explained that they needed more time allocated to Patient School and to planning Patient School workshops. Some described that a dedicated budget for hiring expert lecturers would ease the burden on course leaders. Other course leaders stated that almost all clinics have employed user-involvement coordinators and highlighted that to expand Patient School to additional sites would require either allocation of more staff or more active collaboration between user-involvement coordinators.

Staff attitudes

Several barriers connected to staff and managers' attitudes were highlighted by course leaders. Some described a noticeable reluctance among staff towards including staff with user experience in health care in general. As the Patient School was initiated by user-involvement coordinators and staff with user experience, this affected staff attitude towards Patient School. A drastic example of the consequence of a negative attitude was told by course leaders. On some occasions staff falsely claimed to have reserved the facility where Patient School was to be held. This behaviour was perceived by some course leaders as an indirect expression of staff's doubts about the value of the Patient School. Course leaders felt that some managers also were critical of the Patient School and misunderstood its purpose.

Then there have been some attitudes...obstacles too. There have been certain... Some managers, who have thought that no, should you really teach people to be patients? (Interviewee #7)

A viewpoint expressed by some course leaders was that managers appeared to prioritise financial considerations over quality aspects. They suggested that managers perceived Patient School as less significant as it does not generate income to the provider.

According to course leaders there existed a degree of reluctance Patient School among some staff. They had experienced that staff had actively singled out aspects of Patient School to criticise. This attitude was felt to mirror fear of an increased workload triggering change resistance. One staff interviewee stated that during Patient School sessions patients were encouraged to actively engage in care planning and participate in their care, such as by reading their medical records.

There are people who believe it's, unnecessary, to remind that one can read one's medical record, I heard from a colleague once, since the patient had expressed concerns (about a note and its content). I believe it's evident that patients should be able to read their medical record, and at the same time, also to use it as a tool, as I do. However, not everyone likes it […] So, of course, it's true that some find it worrying that … patients, are well-informed and also that they have demands. (Interviewee #10)

Facilitators on the other hand included the perceived value of the Patient School, which not only influenced the general staff attitude towards Patient School but was also said to impact their willingness to recruit patients to participate. Patient satisfaction with the Patient School was described as a motivating factor leading to the dissemination of information about the programme. For example, one staff interviewee took the initiative to frequently remind colleagues to inform

patients about Patient School. One course leader suggested that staff on some occasions should accompany their patients to Patient School workshops, allowing them to gain firsthand experience of the Patient School and realise its value.

Ways of organising the course

The role of course leaders and the collaboration between them and participants was widely acknowledged as a cornerstone of a successful Patient School. Among the challenges encountered was the issue of equal participation during discussions. Some participants recognised their tendency to dominate discussions, hence, limiting contributions from more quiet peers. The role of course leaders was thus emphasised as vital to directing the discussion and introducing clear topics and to help participants to maintain focus. One staff interviewee highlighted the importance of the course leaders' competence in directing the conversation.

I believe they were very competent at leading […] you need the right person to lead it, someone with knowledge who is responsive and can evaluate how the information is being received by participants. […] And could interfere if a participant started to talk too much […] and quickly redirect the conversation. (Interviewee #10)

Participants expressed their appreciation of the skills of course leaders as moderators and mentioned that they had high trust in them. Course leaders highlighted that they made sure that everyone had a chance to speak and that all topics were covered. By sharing their own experience course leaders encouraged patients to speak up. Those features were seen as facilitating the successful implementation of the Patient School. Conversely, the role and behaviour of course leaders were sometimes described as a barrier. Initially, course leaders at times focused too much on

sharing their own experiences. This trap was avoided by creating clear agendas for sessions. Furthermore, course leaders described that to enhance coherence and promote improved group dynamics the following policy was implemented: if a participant missed the two first meetings, they had to quit the course.

As employees of the psychiatry organisation course leaders knew what psychiatry has to offer. Having user experience, they also succeeded in presenting a balanced view of life. In addition, by countering negative stories with positive examples they wished to provide a nuanced perspective on the life situation of a user, contributing to the perceived value of Patient School.

Course leaders try to balance each other with examples we take from our own lives. That if someone has a very negative experience of a single event […], maybe someone else has a more positive picture. And then we sort of try to balance that with the fact that it can look different (Interviewee #7)

Participants shared various additional observations of a positive experience related to the Patient School. Participants expressed their satisfaction with the course material and believed that the five meetings which had different foci fit well together and progressed in a logical order. They also valued the fact that course leaders were in the position to contact clinical staff and facilitate medical interventions when needed. The practice of course leaders working in pairs was also appreciated, as it enables the leader to have a private encounter with a participant when needed without disrupting discussions within the rest of the group. Furthermore, a guest lecturer providing expert insights was something described as beneficial. On the other hand, on one specific occasion a guest lecturer was critical of psychiatric care which was considered less constructive.

The lens of an implementation research framework

To further highlight the primary focus of the study – the implementation of the Patient School programme - the Patient School was analysed using the additional information provided in the context in relation to the five dimensions of the Consolidated Framework for Implementation Research (Damschroeder et al 2022): i) intervention characteristics as defined by the *content* of the Patient School, ii) its *outer setting*, (iii) *inner setting*, (iv) *individuals*, and the (v) *implementation process*.

Patient School content

The aim of the Patient School was to promote recovery and to reach out to service users by placing the activity in facilities within the psychiatry organisation, and to charge user involvement coordinators and staff with user experience to organise and lead the school workshops.

Each School course consisted of five workshops given over five weeks titled Psychiatry – how does it work?; Recovery –what is helpful?; Other resources in society; Relations and disclosure; and Personal tools. Health care staff from the psychiatry organization and researchers were invited as either co-leaders or substance matter experts.

Outer context

The outer setting of the Patient School was the Region Stockholm, Sweden, comprehensive psychiatry organisation, covering in-hospital care as well as outpatient services. The commitment of the organisation to employ patient-centred practices and ensure user influence and involvement was shown by the employment of persons with user experience as part of the permanent staff.

Inner setting

The inner setting was the outpatient departments offering facilities for in- and outpatients to

join the Patient School, organised by the salaried staff with user experience. The school was backed by supporting clinical staff, informing about the School, and participating in the active recruitment of participants. A barrier was the lack of ear-marked funding and dedicated venues.

Individuals

The individuals involved were high-level managers having instituted the functions of user-involvement coordinators and staff with user experience and supporting their various initiatives. The school organisers benefitted from their own user experience as well as being salaried staff of the organisation. Clinical staff that had positive attitudes to user involvement participated in recruiting participants as well as contributed with information and expert advice. Finally, service users were active participants, sharing their experience, and supporting the continuous improvement of school activities by giving regular feedback.

Implementation process

The implementation process was characterised by the school content, covering practical information on services and support available, as well as skills training, and the creation of a safe environment for sharing experience by the example of the course leaders. Success factors facilitating the implementation process were an “open door policy”, psychiatry staff actively informing service users of the School, the lived experience of the course leaders, positive attitudes among some professional staff and course leaders’ attention to participant feedback. Barrers to successful implementation were lack of dedicated resources, negative attitudes among some staff who had doubts about the benefits of the School, and instances where course leaders or participants dwelled too much on sharing personal experiences thus impeding an open discussion and reflection process.

Discussion

Principal findings

In our study, focusing on the implementation of a recovery college-like Patient School organised by persons with user experience within a psychiatry organisation, we identified activities and attitudes that had both positive and negative impact, i.e., could be both hindering and promoting factors. In terms of *recruitment*, lack of both knowledge about the Patient School among staff and contacts with user-involvement coordinators and staff with user experience were barriers, whereas staff actively informing, information provided during other user activating courses and the open doors policy created opportunities to reach out to potential participants more broadly. As to *resources*, educational activities like the Patient School were not included in the reimbursement scheme for the psychiatry organisation and was consequently felt to compete with service provision generating income, thus reducing the possibility for staff to contribute, and salaried staff with user experience to take on organiser duties. Dedicated funds for the Patient School on the other hand would remove those barriers and make it possible to pay honorariums to external experts. A dedicated venue would also be of help to course organisers. Negative *attitudes among staff* were demonstrated as a negative attitude towards employees with user experience and suspicions about the value of the Patient School, change resistance, and negative views on patient involvement and empowerment in general. Staff that saw evidence of the value of the Patient School had a positive attitude, and recommended patients to join the school. The *ways of organising* the school had negative as well as positive consequences. When course leaders spent too much time on their own experiences and letting single participants dominate the discussions participants felt at unease. On the other hand, that course leaders shared their own experience encouraged participants to express their own concerns. Course leaders who gave everybody space and paid attention to participant feedback were appreciated. Some

expert contributions being out of touch with Patient School principles was experienced as disturbing, whereas the course material was assessed as proper and useful. In summary, course leaders, participants and staff identified the following facilitators of a successful implementation: active recruitment of participants at wards and outpatient departments, information freely available in the same locations, a dedicated budget and venue for course activities, active moderation of discussions during courses, responding to participant needs, adjusting the group dynamics, and paying attention to the feedback by course participants.

The Patient School was favourably assessed by participants, staff and organisers as shown in a previous report (by [removed for peer-review], forthcoming). The perceived value was enhanced by the willingness of peer-organisers to share their own experiences, thus creating a sense of belonging and a forum for sharing with like-minded. In that environment new knowledge, practical skills, roles, and attitudes were acquired. These experiences were felt empowering, they decreased stigma and reassured that one's identity is not defined by the mental health issue.

The thick description of the Patient School based on the comprehensive data reported enables an attempt to present a tentative explanation to these positive outcomes. One way of conceptualising such a "programme theory" is to build on the analysis performed by using the Consolidated Framework for Implementation Research framework (Damschroeder et al. 2022).

The regional psychiatry organisation offered a favourable *outer setting* as demonstrated by its long-term commitment to patient-centred practices and ensure user influence and involvement. An equally favourable *inner setting* were the outpatient departments providing facilities for the Patient School and allowing their salaried staff with user experience to organise the school, although the lack of dedicated funding and venues were seen as impeding school activities. *Individuals* contributing to the School's success were the user-involvement coordinators and staff with user experience as course organisers, clinical staff with positive attitudes to user involvement who helped to recruit participants

and provide those with information and expert advice, and, finally, service users actively participating and sharing their personal experience. The *implementation process* was guided by the school content, providing practical information on services and support available as well as skills training. The willingness of the course leaders to share their experience as service users was instrumental to creating a safe environment for participants, enabling them to openly discuss and reflect.

As emphasised in the introduction, although there is a number of evaluation studies reporting benefits of recovery colleges and educational activities, implementation processes and experiences are rarely described. However, we find some support for our tentative explanatory model. The “enabling environment” of a recovery college has been said to be a key driver of positive experiences among users and families. Challenges are delays in course standardisation and enrolment and attendance procedures. Such barriers can be overcome with a supporting outer setting as well as an inner setting with dedicated staff with user experience and supportive clinical staff [12].

On a more overarching level, the importance of certain characteristics of outer and inner settings have been reported. When assessing several recovery programmes Whitley et al. found four cross-site themes with an impact on success or failure (Witley et al 2009). Those were leadership, organisational culture, training, staff, and supervision. Those themes have implications for the implementation process also. Other authors highlight the importance of values. Programme aims and policies, but also practices like recruitment, staffing and documentation should be “recovery compatible” (Farkas et al 2005).

A more practical approach, as employed by Smith-Merry et al (2011) in Scottish recovery activities, give useful hints on implementation processes also. They recommend the application of four “recovery technologies”: recovery narratives (as practised in the Patient School), the “Scottish Recovery Indicator”, which measures the extent to which services are implementing a recovery-

oriented practice models, a structured tool for service users to manage their own recovery, and peer support. While we did not explore the direct influence of the Patient School on the clinical practice, findings indicate that those elements might be found in the Patient School implementation programme. The Patient School L provided, for example, participants with tools and practices to cope with their challenges, and those were assessed in discussions during the sessions. Exchange of lived experience and peer support was a central part of the programme.

Finally, not surprising, issues on planning and resources are also raised in the literature. Burhouse at al. (2015) emphasise that when organising a recovery activity as a continuous improvement project time for planning is warranted and “sustainability planning needs resources from the start”. The authors also emphasise the importance of finding a robust measure of the long-term cost-benefit to ensure support from decision makers.

Strength and limitations

This study has strengths as well as weaknesses. It describes a case from one psychiatry organisation in Sweden and is based on a limited group of interviewees. Attempts to transfer the findings to other contexts must be done with caution (Stenfors et al 2020). However, it is focused on the context and processes of implementation, which is an angle seldom chosen in studies evaluating recovery colleges and other educational interventions in psychiatric care. Despite being, in essence, a case study, it adopts a framework, widely used in implementation research, enabling us to present a tentative explanatory model for a recovery college, experienced as being valuable by participants. It shows what features in the context that might contribute to the positive impact, as well as the importance of individuals like organisers with user-experience, preconditions in terms of resources and specifics of the implementation process, the most important being an “open door policy” and “giving everybody space”. Other sites and organisations would be well-advised to pay attention to

these features when organising recovery colleges aiming at strengthening psychiatry service users' self-management skills and reducing their sense of stigma. Future studies performed in other contexts and comparing different sites would develop and deepen the understanding of the successful implementation of recovery colleges.

Conclusions

Conditions that will support recovery colleges to reach their goals of empowering psychiatry service users include, first of all: Allocating dedicated resources and engaging, as organisers, individuals with user-experience who are willing to share their personal experience. An additional benefit is provided by these organisers working "in-house" as salaried employees. Equally important is to have an open-door policy, create an open space or participants to share, and offer practical advice and written material felt useful. Future studies comparing various sites would enhance and broaden our comprehension of the effective implementation of recovery colleges across different contexts.

Informed consent

All procedures followed were in accordance with the ethical standards of the responsible committee for human experimentation (institutional and national) and with the Helsinki Declaration of 1975, as revised in 2000. Informed consent was obtained from all patients for being included in the study.

Data availability statement

Due to the nature of this research, interviewees of this study did not agree for their data to be shared

publicly. All documents used are freely available.

Conflicts of Interest

None declared.

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Supplementary Files

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URL: http://asset.jmir.pub/assets/e9e9f7b247758052cc4d8cb8cb1acd0b.docx

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URL: http://asset.jmir.pub/assets/b9270f2137577623d204aad8eb4e621f.pdf

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Figures

Table 2. Summary of barriers and facilitators for the implementation of the Patient School based on interviews with course leaders, participants, and staff and course documents.

BARRIERS	FACILITATORS
- Recruitment • Lack of contacts with fellow service users • Lack of knowledge and understanding of the PS and its benefits among clinical staff	+ Recruitment • Everybody can join the PS • Active information to patients from staff
- Resources • PS not included in the reimbursement system • Focus on service production, less time for staff to support PS • Lack of dedicated venue	+ Resources • UICs and SUEs as course leaders
- Negative attitude among staff • Negative stance towards staff with user experience and patient involvement • Change resistance – fear of heavier workload • "Wrong to teach a person to be a patient"	+ Positive attitude among staff • Patient satisfaction and perceived value of PS increases staff motivation to support PS
- Ways of organising course • Course leaders spending too much time on describing own experience left little space for participants • Some participants dominated too much • Some experts not appreciated by participants	+ Ways of organising course • Course leaders sharing own experience encouraged participants • Moderator giving everybody space • Participant feedback paid attention to • "Open door policy" (everybody is welcome) • Appreciated course material

Table 1. Participants characteristics (n=16).

Participants of the Patient School		Participants, n
Course leaders (UICs or SUE)		4
Clinical staff		4
Course participants		8

Multimedia Appendixes

Timeline of respondent recruitment.
URL: http://asset.jmir.pub/assets/384ace09a7c913b3ff145e7fd246ece1.docx

CONSORT (or other) checklists

COREQ checklist.
URL: http://asset.jmir.pub/assets/4c1bfa3ff3854fdde99c9f380be808e3.pdf