Recovery in Mind

2019 - 2021

A Research Evaluation

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From Heather Yoeli and Jacqueline Sin: lead authors of this report
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From Angela Ryan: Recovery in Mind founder and manager, commissioner of this research
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Executive Summary

Recovery in Mind (RiM) is a Recovery College in West Berkshire which is passionate about recovery, peer leadership, and co-production, and adheres closely to the central ImROC (Implementing Recovery through Organisational Change) principles of hope, control, and opportunity. RiM is led by Angela Ryan, an experienced voluntary sector manager with lived experience of mental ill-health, and by her team of staff and peer trainers, some of whom are seconded from the local NHS Trust, and others of whom are currently funded by the Big Lottery Fund. This research is also funded by a grant from the Big Lottery Fund. RiM has also received a number of smaller grants from other charities.

RiM courses and workshops are organised around a three-stage structure. Firstly (Stage 1), students participate in a brief Recovery Bitesize workshop; this was initially face to face, but since Covid-19 has become an online video. Secondly (Stage 2), students take part in a five-week Welcome to Recovery (WTR) course; since Covid-19 this has sometimes been delivered in a socially distanced face-to-face manner and sometimes online via Microsoft Teams. Thirdly (Stage 3), students are invited to join a range of other classes and activities. The Covid-19 restrictions have disrupted many of these, but the Five Ways to Wellbeing course has continued online, and a number of new active and creative activities have developed, some online, some outdoors, and some held in the allotment which RiM now shares with another community group.

This research aimed to evaluate the impact of RiM and its courses in promoting students' wellbeing and subjective perception of recovery, and to explore and evaluate students' and peer trainers' health-related outcomes and lived experiences of recovery through participation in RiM. The research took a mixed-methods approach, administering the WEMWBS (Warwick-Edinburgh Mental Wellbeing Scale) questionnaire to 89 students and peer trainers, and qualitatively interviewing six students and two peer trainers. This study was designed in co-production between researchers from the Centre for Mental Health Research at Coty, University of London, and the RiM staff, peer trainers, and students.

This research found that students join RiM with very low levels of wellbeing. RiM participation helps students to improve their wellbeing and mental health, though rarely to the extent of matching the general population. RiM may help women more than men, though this is difficult to establish because few men participated in the research. Most students are White middle-aged women who join RiM on the advice of their GPs or CMHTs (community mental health teams). A large number of students leave RiM between the initial

Stage 1 Bitesize session and the five-week Welcome to Recovery course, though it is unclear why, and unclear whether Covid has affected this.

Students described the most valuable skills as mindfulness, being aware of one's surroundings, creativity, and being with others. Students used the skills taught and learned in the RiM classes, and the toolbox metaphor around which these were structured, to develop increasingly personalised strategies to improve their longer-term wellbeing and resilience. Even for those students who had received mental health support in the past, much of what RiM taught was new, either in the course content, or in the manner of its delivery. Being part of RiM, and being among others who understood, helped students to practice the skills and strategies they were developing. Students gave and received a huge amount of support to and from one another. They spoke fondly of the staff and peer trainers, and especially of Angela, and drew inspiration from the teamwork they observed from the RiM leadership.

Both of the peer trainers interviewed had found being an RiM student extremely helpful to them, and both are now passionate advocates of RiM and of the concepts of recovery and co-production. They enjoy supporting other students, and find that the peer trainer role goes beyond their lived experience to enable them to use their other skills.

The Covid-19 pandemic has affected the entire lives of everyone at RiM, and many students and peer trainers have found the past year immensely difficult. Nevertheless, students have welcomed the way that RiM has adapted to offering online and socially distanced outdoor activities. In particular, students have valued the way that RiM has helped them to feel connected to others and to their local community.

From this research, RiM has learned a number of things:

1. RiM's so-called "hidden curriculum" of mutual peer support, local inclusion, and collective empowerment is as effective and as valued by students as RiM's visible structure, stated aims, and course content. RiM may benefit from continued reflection upon this "hidden curriculum".

2. Through being led by a person with lived experience of mental ill-health, RiM adheres with fidelity to the Recovery College ethos. However, its high level of co-production does not sit comfortably with the governance structures of the NHS services with which it seeks to partner, raising a number of difficult philosophical and ethical challenges. These are challenges not just for RiM and for the Recovery College model, but for all mental health services seeking to work equitably with people with lived experience.

3. Students come to RiM with extremely low levels of wellbeing. This may be due in part to the disruption of Covid-19, but may also be because many join RiM after discharge from the CMHT with significant unresolved mental health needs. The Stage 2 WTR course helps students to improve their wellbeing, but these gains are not always sustained, perhaps due to the lack on onward opportunities during Covid-19. RiM may wish to explore this further.

4. Many students who undertake RiM’s Stage 1 Recovery Bitesize do not progress to Stage 2 WTR, and some students who start WTR do not complete it. Neither the recording mechanisms of RiM nor the methodology of this research are sufficient to understand why this is. It may be that, by tracking these students, RiM could learn things which may help it improve.

5. Whereas RiM is committed to and pro-active about promoting diversity, its catchment area is predominantly White, and RiM students are generally White, middle-aged women. Due to the disruption caused by Covid-19, fewer students than anticipated took part in the WEMWBS evaluation, with the result that it was difficult to evaluate RiM’s effect on men or BAME people. In seeking to encourage diversity, RiM is aiming to promote positive mental wellbeing as well as addressing mental ill-health. In so doing, RiM may benefit from seeking students from other sources: for example, further education colleges, youth clubs, faith communities, and other community projects.

In moving towards the future, RiM’s greatest need is for sustainable funding.

Preface

One day you finally knew
what you had to do, and began,
though the voices around you
kept shouting
their bad advice—
though the whole house
began to tremble
and you felt the old tug
at your ankles.
"Mend my life!"
each voice cried.
But you didn't stop.
You knew what you had to do,
though the wind pried
with its stiff fingers
at the very foundations,
though their melancholy
was terrible.
It was already late
enough, and a wild night,
and the road full of fallen
branches and stones.
But little by little,
as you left their voices behind,
the stars began to burn
through the sheets of clouds,
and there was a new voice
which you slowly
recognized as your own,
that kept you company
as you strode deeper and deeper
into the world,
determined to do
the only thing you could do—
determined to save
the only life you could save.

Mary Oliver (1), quoted in Recovery in Mind newsletter No. 15 (2)

Chapter 1 Glancing in the Rear-View Mirror

How to use the rear-view mirror – it's one of the things you need to know when you're learning to drive, isn't it? Keep staring into it and you'll never leave the driveway, but at the same time, you can't not look at what's behind you, either…

Angela Ryan,
Recovery in Mind founder and manager

The landscape behind

NHS mental health services in 2015: austerity and recovery

> From the perspective of the individual with mental illness, recovery means gaining and retaining hope, understanding of one's abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life and a positive sense of self…
>
> World Health Organisation 2012, p.41 (3)

Since 2012, "recovery-orientated" treatment, care and support has been regarded as a human right for mental health service users worldwide (3). The concept of "recovery", or the "Recovery Model", has been evolving within UK mental health services since the early 2000s (4, 5). Initially, the recovery concept originated within the service user movement as a reactionary and radical challenge to the historic notion that people living with mental ill-health were untreatable, and thereby should be made to remain dependent upon medical professionals, and could justifiably be excluded from mainstream forms of social and economic participation (6, 7). In its earliest inceptions, the Recovery Model emphasised co-production, political activism, and the centrality of peer support (8, 9).

Within the late 2000s and early 2010s, concepts of recovery and the Recovery Model entered NHS services as neoliberal policy discourses around person-centredness and behaviour change combined with austerity, task-shifting, and disinvestment in mental health provision (10, 11). Within this form, the Recovery Model has acquired additional emphases on personal self-efficacy, individual re-enablement, and choice (12, 13). Some mental health service users have criticised the mainstreaming of recovery as a cost-cutting technique to push patients off CMHT caseloads and into employment (14, 15), and some mental health professionals and academics have criticised the exclusionary or coercive

potential of statutory services created to direct service users towards recovery (5, 16). Most service users and practitioners, however, recognise that the optimism and empowerment of the Recovery Model offers people living with mental ill-health broader and more satisfying life chances than the pre-recovery NHS (17, 18).

The Recovery College model

In the UK, the Recovery College model was developed by Julie Repper, Rachel Perkins, and colleagues from ImROC (Implementing Recovery through Organisational Change) (19). The first Recovery Colleges were established in South West London in 2009 (20), and Nottingham in 2011 (21). As of 2020, there were estimated to be approximately 80 UK Recovery Colleges, with an increasing number operating outside the UK.

The Recovery College model is guided by three key values of hope, control, and opportunity, and by the aim of providing individuals and communities with the skills to improve their own personal and collective mental wellbeing. In so doing, Recovery Colleges seek intentionally to function as educational rather than therapeutic institutions: participants are students not patients; students register for courses rather than are referred onto them; and students attend classrooms rather than day centres (20, 22-24). They adhere to an emancipatory and action learning educational model which is distinctively grounded in co-production by valuing the lived experiences of people living with mental health challenges (20, 25, 26). People with lived experience must therefore be involved at all strategic and operational levels of Recovery College planning, development, governance, and delivery. “Peer trainers”, or former students, must be involved in the running of Recovery Colleges, and in their planning and delivery (20, 27). Peer trainers must be invited not only to offer their lived experiences of mental ill-health and recovery, but their broader personal and vocational skills (20, 28). Peer trainers must be employed and appropriately paid for their work (27).

Over the past ten years, the Recovery College model and Recovery Colleges themselves have been extensively researched (22-24, 28-32). Findings from this research have sometimes provided mixed results both because research methods have varied in their validity (33), and because different Recovery Colleges adhere to the Recovery College model with varying levels of fidelity (27). Nevertheless, the most comprehensive and recently published systematic review offers a strong evidence base from which to claim that Recovery Colleges are effective and valued by students, and lead to lasting organisational change within mental health services (22). This research is an evaluation of Recovery in Mind, a Recovery College based in West Berkshire.

The Recovery in Mind auto-mechanics

Angela

Angela Ryan is the founder and manager of Recovery in Mind. She worked for many years in voluntary sector leadership and governance for a number of charities. This career was interrupted by an episode of psychosis, which provided Angela with valuable lived experience of mental health challenges and of receiving treatment and care from local mental health services. What Angela found most effective was the support she received from a Recovery College, because she found their approach so de-stigmatising, optimistic, and skills focused. Angela established Recovery in Mind to enable others struggling with their mental health to receive the help from which she herself had benefitted.

Fiona and Cath

Fiona Habermehl and Catherine (Cath) Hensby are employed by Berkshire Healthcare NHS Foundation Trust as Occupational Therapists and are each seconded to work about half-time hours for Recovery in Mind. Fiona and Cath have many years of experience as group facilitators. Before joining Recovery in Mind, they had worked together within the local CMHT, where they had increasingly been finding that their group-based and re-enablement skills were not fully utilised. They were keen to work with Angela in developing Recovery in Mind because they regarded Recovery Colleges as aligning well with their professional values of client-centredness, empowerment, and asset-based practice.

Sarah and Gillian

Sarah Burton and Gillian Bandy are retired NHS Occupational Therapists employed part time by Recovery in Mind with their positions funded by the Big Lottery Foundation. Sarah is a fine artist and trained in person-centred art therapy, and she facilitates many of Recovery in Mind's creative group activities. Gillian is a Reader Leader within the Shared Reading movement; she facilitates Recovery in Mind's reading group. They enjoy working for Recovery in Mind because of the flexibility and freedom it provides them to develop new ways of supporting individuals to overcome their mental health challenges.

Alex

Alex Luke was Head of Mental Health for West Berkshire with Berkshire Healthcare NHS Foundation Trust until 2019. Alex identified upon her arrival that West Berkshire mental health services offered little of the group work or co-production available elsewhere in the UK and in particular at SLaM (South London and Maudsley NHS Foundation Trust) where she had worked before. She was excited, then, to learn about Angela's interest in the Recovery College model, keen to support Angela's vision for a Recovery College in West Berkshire,

and keen to provide Recovery in Mind with Fiona and Cath as professional staff. Alex has been a Recovery in Mind trustee from the outset and has remained a trustee since moving to another job.

Helen

Helen Rigby is a self-employed bookkeeper who manages all aspects of Recovery in Mind's finances and administration and maintains its website. She has also herself undertaken Recovery in Mind's Self-Compassion course. Since the start of the Covid-19 pandemic, Helen has led Recovery in Mind's transition from classroom-based and outdoor courses to online provision and continues to work with students to overcome any technical challenges to participation in these.

Andrea

When Angela decided to start Recovery in Mind with no finances and little idea of what she had let herself in for, her neighbour, Andrea, offered a helping hand. Andrea has a vast amount of commercial experience and experience of running a business. Andrea worked out the process for student bookings, created the first website, and managed all the student and venue bookings for the first 18 months. She was Angela's co-driver in the very early days when help was needed to keep going in the right direction and ensure process, and she helped Angela and the team enormously. Andrea worked as a volunteer, often giving 20 hours a week to the venture, and supported Angela to get on the road and into second gear.

The peer trainers

Recovery in Mind's six employed peer trainers are integral to all aspects of Recovery in Mind's vision, values, and day-to-day functioning. Each of them has lived experience of mental ill-health and a diversity of further skills, and each has previously benefitted from their time as a Recovery in Mind student. They were selected as peer trainers on account of their self-awareness, approachability, listening skills, empathy, warmth, and ability to share their lived experience in a positive way with students. Two of their stories are profiled in the case studies of Chapter 7.

Chapter 2 Gaining our Driver's Licence

> Back in 2013 when I was very unwell with psychosis and virtually unable to leave my house, I looked out the kitchen window one afternoon and thought I had come up with the answer to all my problems. If I had a shed at the bottom of the garden with my GP, the psychiatrist and mental health nurse who all supported me, then whenever I became distressed, frightened, or overwhelmed, I could shout out of the window, and they would run up to the house to sort me out. Easy. They would give me all the time I needed, make me feel able to cope knowing they were 'on tap' and would never be far away. But I realised that however much I thought this would be the answer, I was aware of the flaws in my plan. Once I became reliant upon them, I would probably need to take them wherever I went, to ensure my ongoing wellbeing. Tricky – the car wasn't big enough as I had a small baby at the time – let alone all the other logistical problems…

Angela Ryan (34)

It was at a Hampshire Recovery College that Angela realised that she no longer wanted her mental health team shelved among spare tyres, car jacks, jump leads, air compressor, and brake cleaner. What she wanted instead, she realised, was her own portable recovery toolkit, a toolkit that she herself could design, construct, and fill with the skills that she herself could develop, enabling in her the independence, autonomy, and self-management which peer support teaches. She wanted to take back control of her own vehicle (and life) after losing the ability to even get into a vehicle. She found the Recovery College courses and support enabled her to get back into the driving seat, plan her own journey, and get back out onto the road of life once more. She needed to learn how to maintain her vehicle, using the tools and developing her own road map for her own personal recovery. As she continued to build her own toolkit, Angela also began to dream about the construction of a

Recovery College for the people of West Berkshire struggling with their mental health. A Recovery College which could serve as a vehicle for peer support in driving students forward in their recovery journeys together…

2016 The journey begins

Angela entered 2016 determined to advocate and to lobby for a West Berkshire Recovery College. She joined local mental health user groups and PPI (patient and public involvement) forums, meeting with commissioners, managers, and other influential figures within West Berkshire statutory and voluntary services, and explaining to each the value of Recovery Colleges and the need for a West Berkshire Recovery College. Soon, Angela met with Julie Repper, the co-lead of ImROC, and co-founder of the Recovery College model. It was Julie who suggested that Angela should start building this Recovery College herself.

As an experienced voluntary sector manager, Angela had long known that social innovation requires not only a clearly articulated vision, but also skills in networking, collaboration, and perseverance. She therefore approached Alex Luke, who was at the time the mental health service lead for West Berkshire, explaining to her the concept and ethos of Recovery Colleges, and outlining her ideas for constructing a local Recovery College. Alex was keen to endorse and to support this vision, and seconded to Angela two Occupational Therapists from the local CMHT, Fiona Habermehl and Cath Hensby. Angela then applied for a grant with UnLtd, which offered funding and mentoring to social entrepreneurs and to their newly established community interest companies. Angela successfully 'won' an 'award' (grant) with UnLtd, who also provided her with the skills to run the venture and some funding to help with the initial start-up costs so that she could dedicate herself full time to Recovery in Mind. With staff and finances on board, Angela was now able to manoeuvre the gear stick to a forward position and to place her keys into the ignition. Recovery in Mind was now moving. UnLtd gave Angela the confidence to get the vehicle on the road and to learn the basic mechanics of running a community interest company.

As Angela commented:

> It's amazing what you can do with very little financial resources and I didn't need a Ferrari, just a Charabanc for us all to pile into and get on the journey.

Angela, Fiona, and Cath designed their first Recovery in Mind course Welcome to Recovery at a local café in Newbury, which back then offered free coffee as well as free parking. Andrea was back in the garage getting the vehicle on the road ready for the team to jump aboard. Potential students were identified from among service users of the local CMHT, many of whom had spent many years in local services and appeared to need some additional support in moving forward. When Welcome to Recovery was ready to pilot, in May 2016, Recovery in Mind hired an office and classroom in Broadway House in the town centre. This first course proved hugely successful. Angela, Fiona, and Cath ran their next course, Five Ways to Wellbeing, in September. From here, Recovery in Mind gathered speed, acquiring a permanent base within Broadway House in November 2016, and appointing two of the hitherto most successful and engaging students to take up and develop the peer trainer role.

2017-2019 Accelerations and expeditions

As Recovery in Mind continued its journey apace, the team was joined by retired Occupational Therapists Sarah Burton and Gillian Bandy, by bookkeeper and administrator Helen Rigby, and by a team of energetic and creative ex-student peer trainers, each of whom brought to Recovery in Mind their unique experiences and skills. Angela continued to work assiduously in fundraising to ensure all Recovery in Mind courses could be delivered at no cost to students, and attracted grants from the Local Authority, local Community Foundation, and a range of smaller local charities. Angela, Fiona, and Cath continued to plan and deliver a range of new two-and-a-half-hour-long weekly courses to be run over each half term – for example, Five Ways to Wellbeing, WRAP (Wellness Recovery Action Planning), Reading for Recovery, Recovery Street (a photography course recording the student's recovery journey), and Self-Compassion – and half-day standalone workshops on topics such as Mindfulness Walking and Creativity for Recovery. New students were expected to attend a brief introductory one-off Bitesize course, followed by the five-week Welcome to Recovery (WTR) foundation course, and they were then invited to enrol on any of the other courses and workshops suiting their own needs and interests. In addition to preparing students for Step 3 courses, WTR also encourages participants to consider other local community activities which might improve their wellbeing: for example, volunteering, sports, and outdoor activities.

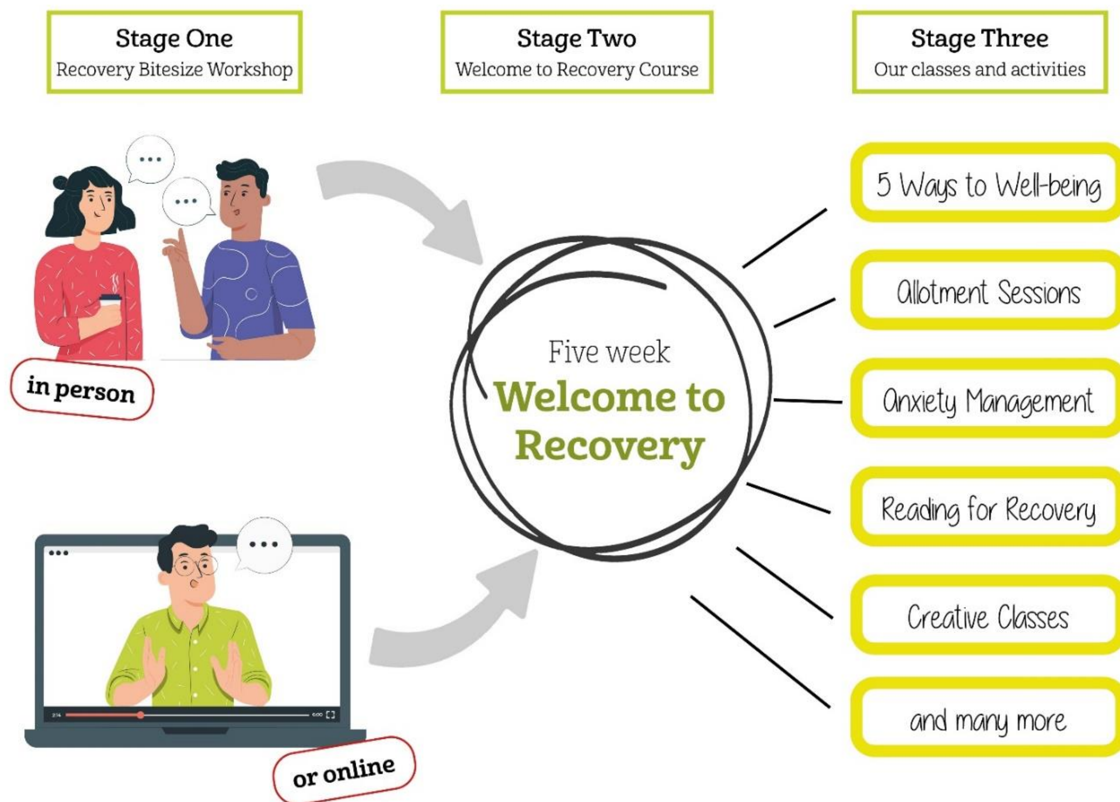


Figure 1 Diagram of three-stage model

Because West Berkshire is more rural than the urban settings typical of many Recovery Colleges, and because Angela and many others of the staff and peer trainers have hobbies and interests centred upon the natural world, Recovery in Mind developed a number of particularly creative and successful outdoor activities. Especially successful among these were the Mindful Walks, designed and led by peer trainer Toria, and the Wellbeing in the Wild Day, which challenged students to expand their personal horizons and build their confidence by trying activities such as campfire building, drawing in nature, and group yoga.

As Angela continued to drive Recovery in Mind forward, she continued to develop existing and new partnerships with other services. Recovery in Mind developed courses and workshops in collaboration with staff from the local PTSD (post-traumatic stress disorder) and EIP (Early Intervention in Psychosis) teams and worked increasingly with local charity Sport in Mind to encourage student participation in physical activity.

In common with most Recovery Colleges, Recovery in Mind sought to emphasise the role of creativity in promoting mental health and wellbeing, running a number of art and craft courses. Recovery in Mind exhibited student photography in its Recovery Street Exhibition at Prospect Park Hospital (where many students had previously been inpatients) and at The Base Gallery at Greenham Common.

In 2018, Angela secured £78,000 over two years from the Big Lottery Reaching Communities Fund. This provided some long-term care and maintenance as the vehicle needed more resources and extra drivers. This research covers the initial two years of this grant (April 2019 – April 2021), plus the extension to September 2021 kindly provided in response to the Covid-19 situation.

By the end of 2019, Recovery in Mind had delivered almost twenty different courses and activities, with some such as Welcome to Recovery repeated up to six times each year. By the end of 2019, Recovery in Mind had delivered courses to over 300 students and had employed six peer trainers. The peer trainers had all moved forward with their own recovery and had cemented their role within the team. Everyone had a role to play, whether as drivers, mechanics, or those back at the depot ensuring the fleet of courses was being well cared for and that new students were joining our journey all the time. Recovery in Mind was motoring along quickly.

Chapter 3 Diverted Off-Road

Coronavirus, Oh what a pain!
But I certainly won't let it drive me insane
Recovery in Mind will help me through
Family, friends and POSITIVES too.

The News is on, I could have cried
"Turn that news off, And go outside!"
The birds are so busy – the blossom is out
We'll conquer this virus I have no doubt.

We will get through this difficult time
The "Toolbox" is open and we will be fine
Listen? I can hear Angela about to call…
…"We'll all soon meet up and have a ball!"

Esme, peer trainer (34)

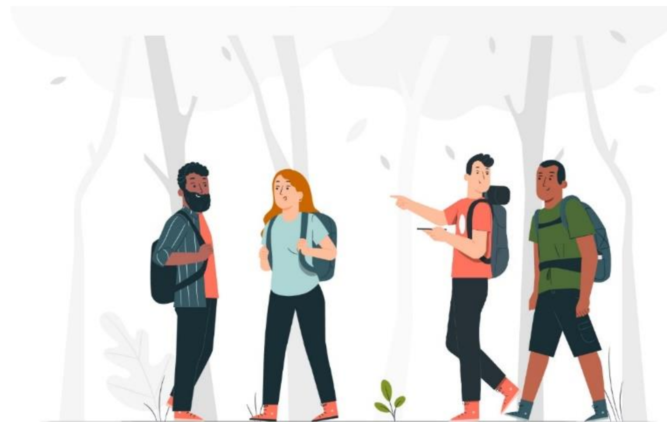
The first Covid-19 lockdown of March 2020 brought all of Recovery in Mind's usual classes and activities to a standstill. Recovery in Mind's initial response was to start a weekly email newsletter for distribution to all current and former students and peer trainers (35). This contained themed motivational and inspirational messages written by Angela, wellbeing tips and tricks written by Fiona and Cath, a craft activity produced by Sarah, and photography, wordsearches, and poetry and other creative writing contributed by everyone – staff, peer trainers, and students. Gillian shared her passion and experience by sharing poetry, stories, and reflections which all proved popular with the students. Recipients warmly fed back that they were finding this newsletter hugely helpful to their ongoing recovery journeys, and Helen has continued to collate and email this to a mailing list of over 350 people each week since.

As the lockdown lengthened, the Recovery in Mind leadership realised that they would need to drive forward through the internet to continue to reach and engage with students. In July 2020, Angela and Cath converted the Introduction to Recovery Bitesize into a short film (36), produced in a local garden to be emailed to students wishing to enrol on the Welcome to Recovery course. Angela, Cath, and Fiona also produced a short series of intentionally very brief online nano-courses (37) and relaxation exercises (38), and Helen posted these on the

Recovery in Mind website as a freely accessible resource to all struggling with anxiety or worry caused by the pandemic.

With the partial lifting of restrictions in the summer and autumn of 2020, Recovery in Mind continued its off-road journey by experimenting with a range of socially distanced outdoor activities. Particularly successful were the new Walk and Talk sessions, within which students, peer trainers, and staff were placed together into groups of six to discuss a given topic while walking.

In September–October 2020, Recovery in Mind resumed face-to-face interaction by delivering Welcome to Recovery in the local council chambers, a larger and more Covid-secure venue than the previous premises. This was followed in November by another Five Ways to Wellbeing course; the November 2020 lockdown was announced however after the first session. Rather than cancelling the remaining sessions, the Recovery in Mind team decided to move the remainder of the course online using Microsoft Teams, a move facilitated by Helen's technical skills.



In December 2020, Recovery in Mind resumed some outdoor sessions, culminating in a socially distanced Festive Walk.

In January 2021, the UK returned to full lockdown. It was a bumpy road for a while. Angela thought that Covid might take the vehicle off the road entirely, but the team kept pushing it over the bumps when things were difficult and kept one another on track. Essentially, Covid-19 pushed RiM forward to utilise IT and start producing online courses. The team weren't keen at first to adopt new ways of working but in order to keep the wheels turning it was an essential diversion and one that has helped RiM to offer a variety of learning opportunities for its students. Angela comments that:

> The vehicle is now more finely tuned, and we are now more confident with what's 'under the bonnet' and how to keep her on the road.

Chapter 4 Going in for the MOT

What is research?

When studying most forms of professional practice or health services organisation, research is about finding things out or creating new knowledge in an objective and value-neutral way (39). When studying user-led or co-production initiatives, however, research is about appropriating and extending organisational values – in the case of Recovery Colleges, those of hope, control, and opportunity – to amplify the voices of the historically least-heard participants, and to challenge their marginalisation (40). Therefore, this Recovery in Mind study seeks not only to discover how or how well RiM has been operating, but also to consider more broadly the value of its structure, its courses, its peer trainer role, and its concept of recovery in informing societal responses to people living with mental health challenges.

What is mixed-methods research?

All research is either quantitative or qualitative in nature, or alternatively, like this RiM study, a mixed-methods combination of quantitative and qualitative (39). Quantitative research uses numbers to measure and to compare. Questionnaires which ask participants to assign a numerical score to their symptoms at regular intervals (for example, the Warwick-Edinburgh Mental Wellbeing Scale or WEMWBS (41) used in this RiM study*)* can be used to measure how an individual's mental wellbeing progresses over time, or to compare how different members of a cohort are progressing (33). Qualitative research uses words (or sometimes images or creativity) rather than numbers, and explores, compares, and conceptualises what cannot meaningfully be measured: emotions; opinions; experiences. Interviews which non-directively enable participants to respond to questions in their own way (as were undertaken within this RiM study) invite researchers to understand how participants view the world, something essential in understanding more existentially what recovery means (14, 42). Mixed-methods research combines quantitative and qualitative research to gain the advantages of both (29, 43): this study sought both to establish whether RiM was of observable and demonstrable benefit to students and peer trainers, and to explain why students and peer trainers assert this to be the case.

What did this RiM study seek to achieve?

Within the design of the project supported by the Big Lottery Reaching Communities Fund running from April 2019 to September 2021 (originally March 2021, extended due to Covid-19), a research study using mixed-methods is embedded.

Research aims

Our study aimed to evaluate the impact of Recovery in Mind and its courses in promoting students' wellbeing and subjective perception of recovery, and to explore and evaluate students' and peer trainers' health-related outcomes and lived experiences of recovery through participation in RiM.

Specific research objectives include:

1. To evaluate the impact of RiM Steps 1 & 2 courses in improving student and peer trainer mental wellbeing (measured using Warwick-Edinburgh Mental Wellbeing Scale or WEMWBS) (41) over time and up to 3-months follow-up. To evaluate the impact of RiM Steps 1 & 2 courses in improving students' subjective perception of recovery in achieving their own goal over the course and up to 3 months after completing the Welcome to Recovery course
2. To explore students' personal recovery journeys through RiM through individual semi-structured interviews
3. To explore peer workers' personal recovery journeys through facilitating and running RiM courses, through individual semi-structured interviews and the WEMWBS and subjective goal review scales
4. To compile a portfolio of recovery journeys of both participants and peer workers by triangulating and corroborating quantitative and qualitative data.

Research participants

All participants were either students or peer trainers of RiM. This meant that all were:

1. Aged 18 or over
2. Living with self-described mental health challenges (however, formal diagnoses were not required or recorded, and self-reported diagnoses were not verified)
3. Living in West Berkshire, or registered with a GP from within the West Berkshire CCG.

For peer trainers, this meant that they had also been involved in delivering courses in RiM over the research period, as described in Chapter 2.

Quantitative research (see Chapter 5)

Research method

For the quantitative within-subject repeated measures part, two questionnaires were used:

1. The Warwick-Edinburgh Mental Wellbeing Scale, or WEMWBS (41). This is a self-report measure of positive mental wellbeing that comprises 14 positively worded statements (examples include "I've been feeling optimistic about the future" and "I've been feeling useful"), rated on a 5-point Likert scale (1 = none of the time to 5 = all of the time). WEMWBS scores range from 14 (minimum) to 70 (maximum); the higher the score the better the individual's mental wellbeing, and a change of 3 points in WEMWBS represents the minimum clinically important difference (MCID) (44, 45). WEMWBS has been widely used in epidemiological studies including the Health Surveys in England (HSE) since 2009, thus allowing us to compare the study sample data with the population norms from published English population survey statistics (46)
2. A two-part question to establish a subjective evaluation of achievement of a personal goal. This comprises an open question, "This is space to write a personal goal that you would like to achieve through the Recovery in Mind courses", followed by a Likert scale of 0 (worst) to 10 (best) for the participants to rate themselves in terms of achieving that.

We asked all Steps 1 & 2 students and all peer workers involved in the delivery of the project to undertake the WEMWBS and personal goal questionnaire at four time points:

T0 At the Step 1 course
T1 At the beginning of Step 2
T2 At the end of Step 2
T3 Three-month follow-up after Step 2

Data analysis

All outcome measures and demographic data of participants (including students and peer workers collectively) were coded with unique identifiers to anonymise them. Data handling and editing were undertaken using SPSS software version 26 (IBM SPSS Inc, Chicago IL). We computed the descriptive statistics for demographic variables (including age, gender) and outcome variables (e.g. WEMWBS average) to present the summary figures in the most appropriate manner, such as numbers and percentage for categorical data (e.g. proportion of male and female students) and mean and standard deviation (SD) for continuous data

(e.g. age, WEMWBS scores). Participants' mental wellbeing (at T2 & T3 respectively) were then compared to the population norms on the WEMWBS (i.e. HSE 2016) and their own baseline scores (T0 or T1 depending on data availability) using independent-samples or same-sample t-tests, and non-parametric tests, with alpha set at 0.05 for all analyses. The data collected on the subjective rating of personal goals were analysed descriptively.

Missing data on WEMWBS were dealt with by replacing missing and incomplete WEMWBS items with the average value of the other item values. This technique is considered acceptable for up to three missing items in a given individual WEMWBS score (47). Cases with greater than three missing items were excluded altogether.

Qualitative research (see Chapters 6–7)

Sampling and recruitment

When the research was first designed in 2019, researchers envisaged a purposive approach to sampling which could be employed to identify those participants most representative of student and peer trainer diversity. However, Covid-19 meant that many of the students and peer trainers who would otherwise have been eager to participate were no longer able to do so for a variety of reasons: some had assumed additional caring responsibilities; some were not comfortable with being interviewed remotely; and some were struggling with the mental health impact of the lockdown and were finding it difficult to talk. As Covid-19 disrupted study recruitment, researchers therefore moved towards a more pragmatically driven convenience model of sampling which, while no longer strictly purposive, continued to reflect the diversity within RiM. Although RiM students and peer trainers are largely White British women in their 40s and above, the sample included one woman in her early 20s, one woman of other European ethnicity, and one man. The researchers sought intentionally to engage students who had expressed varying levels of satisfaction with RiM courses, and sought to include students with varying responses to RiM's move online during Covid-19. Because RiM does not seek or record information regarding student or peer trainer sexual orientation, disability, or other protected characteristics, the study did not seek to recruit purposively from members of the associated minority groups. Of the individuals invited to participate in interviews, six students and two peer trainers agreed to do so.

Interviews

Semi-structured topic guides for the student interviews were designed and piloted by RiM staff, peer workers, and students, working together in accordance with the co-production ethos of RiM. Student interviews were carried out over the telephone by Sarah Burton (SB), as one of the staff members who had previously worked least closely with students. Peer

trainer interviews were intentionally less structured because they sought to ask participants less specifically about their RiM experiences but more generally about their lived experiences of recovery and their peer trainer roles. Peer trainer interviews were carried out using Microsoft Teams by Heather Yoeli (HY), as a lay researcher with no prior involvement with RiM. Interviews ranged in length from 30 to 60 minutes.

Analysis

Following each individual interview, the audio recording of the discussion was transcribed. Researchers checked and ensured that transcriptions were an accurate record of the recordings, before carrying out thematic framework analysis (48) with the aid of NVivo12 research software. This framework analysis, undertaken by HY with the support of Jacqueline Sin (JS) and the wider team, was used to write up the findings of Chapter 6. The case studies of Chapter 7 were written by HY from the interviews with both peer trainers and two students.

Ethics

Ethical approval for this study was obtained from the University of Reading Research Ethics Committee on 15th May 2019 (reference: UREC 19/21). The research team adhered to both RiM and the University of Reading Code of Good Practice in Research, including considerations on information management and data security, confidentiality, and safeguarding. Participants were all fully capacitous in providing freely informed consent evidenced by their signed consent forms. Participants confirmed that they understood that their participation was voluntary, and that they were at liberty to withdraw from the study at any time without providing a reason for doing so. Participants explained that they all understood the principles of confidentiality and anonymity and how the researcher was bound by a duty of care which meant that safeguarding concerns might limit their right to confidentiality. None disclosed any issues of harm or risk to self or others that required researchers to consider the need for any such reporting.

As is the usual practice within qualitative research, all participants were offered pseudonyms. Peer trainer Lynn, however, preferred that her real name be used. She understands that she may be identified, and she would feel comfortable being identified. One of the foremost ethical duties of researchers working within the field of health is analogous to that of the non-maleficence principle of clinical practice: before s/he does anything, the researcher must ensure that s/he inflicts no harm upon participants, especially if the study is unlikely to benefit that individual personally or directly (49). The Covid-19 pandemic has caused researchers to reconsider how they might expose participants to

Covid-19 infection, or the pressure or stress they might inflict by asking participants who are already in stressful or precarious situations to join their study (50). Given the mounting evidence that the pandemic was proving so detrimental to the wellbeing of those whose mental health struggles had pre-dated Covid-19 (51), neither the RiM management nor the research team wanted to add to student or peer trainer stress by making them feel in any way pressurised into participating in this study. Therefore, the move from purposive to convenience sampling was, while methodologically questionable, nevertheless ethically justifiable.

Quality assurance

Even prior to Covid-19, research into Recovery Colleges has always faced a number of unique challenges in demonstrating its validity and reliability (29). In particular, it has always been known that Recovery Colleges are most successful in engaging a particular demographic of mental health service users, and find it harder to reach others. Because Recovery Colleges, unlike most mental health services, operate on a purely self-referral and opt-in basis (20, 32), people who do not like the idea of joining tend not to, and those who find Recovery Colleges unhelpful tend to leave. Students who participate in research into Recovery Colleges tend, therefore, to be those who have benefitted from them, meaning that research into Recovery Colleges tends to generate very positive findings. This study sought to mitigate against this potential bias by purposively seeking to recruit from the minority of students who, while engaging with RiM, were not finding their participation unproblematic. Conversely, because Recovery Colleges have a strong ethos of encouraging students and peer trainers to move forward with their lives (20), they do not necessarily retain contact details for successful and satisfied former students who might generate the most positive findings. This is a known challenge in Recovery College research.

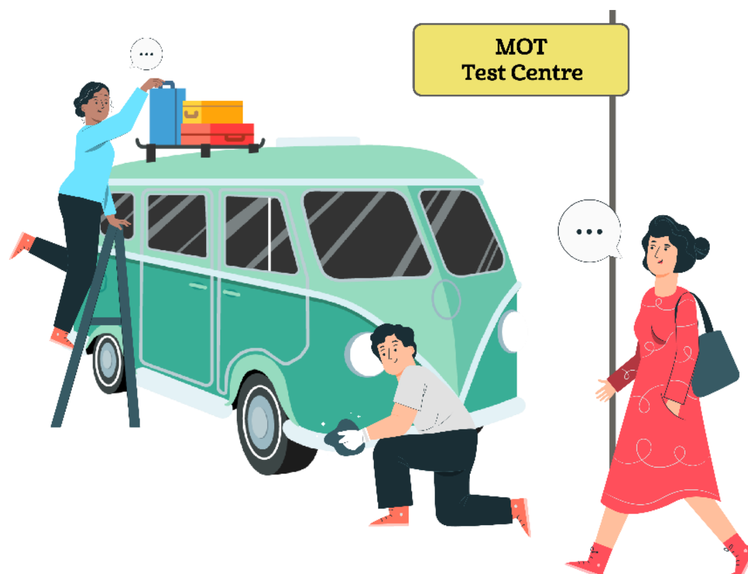
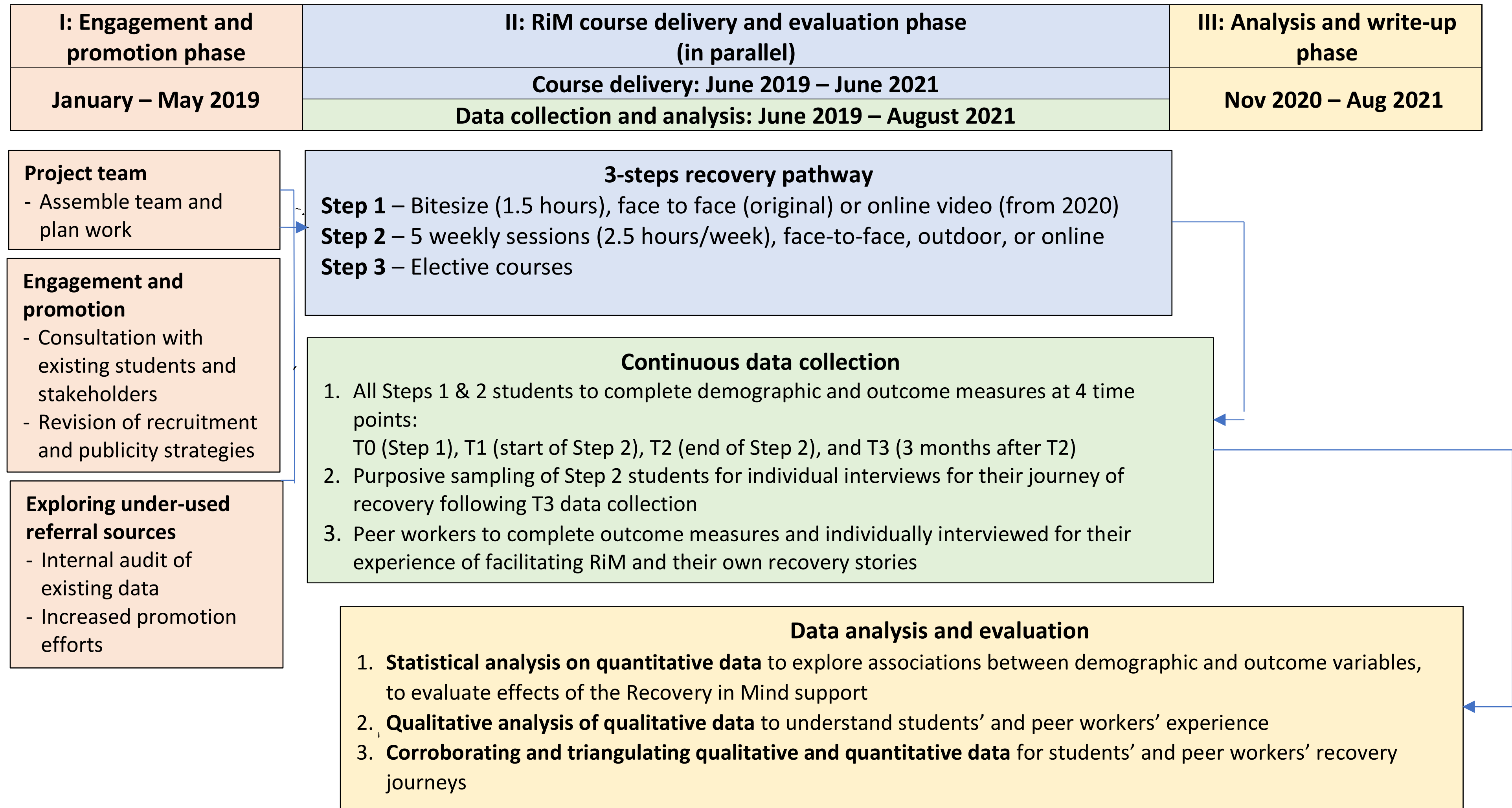


Figure 2 Flow diagram of study design



Chapter 5 Looking at the Dashboard

Participant sample characteristics

More than 110 participants joined the RiM Step 1 and 2 courses over the study time period. This was a period of time repeatedly interrupted by the Covid-19 pandemic and by the public health restrictions this brought about.

Eighty-nine students completed the questionnaires at T0, i.e. at the beginning of the Bitesize course. When it became necessary to deliver the Bitesize course as a video link, for those who enrolled online to watch it from their own home during the lockdown periods, no questionnaires were sent as it was felt inappropriate without an opportunity for the team to explain the research properly. The students' ages ranged from 18 to 78; the mean[a] age of students was 47 years (standard deviation or SD=14[b], median=47[c]). A majority of students were female (n=63[d], 70%); the remaining 26 (30%) were male. Reflective of the local demographics of ethnicity, over 85% of the students (n=75) were White British with a further six students from other White backgrounds. The remaining eight students comprised one White and Black Caribbean, two of mixed ethnic heritage, one Indian, three Pakistani, and one unspecified. In terms of employment status, 47% were in paid employment (n=37) or were self-employed (n=5), 10 were retired, 33 unemployed with half of these (n=16) looking for a job at the time, three further were in voluntary work, and one did not report any details. A similar proportion of students reported that they heard about RiM through their GP (n=29) and CMHT (n=27). Ten students learned of RiM through their friends, five from publicity events or social media, and 17 from unspecified sources.

At T1, i.e. the beginning of the five-session Welcome to Recovery (W2R) course, 71 students completed the quantitative measures. Two-thirds of these students (n=47) were on the face-to-face courses; 27 started their W2R course online. The demographic characteristics of the students at this time point are similar to that reported at T0, as most students would have undertaken the Bitesize session within the last 18 months although a small fraction had been to the Bitesize prior to this project starting in mid-2019. At T2, i.e. at the end of

[a] In statistics, the mean is what is otherwise usually referred to as the average. It is reached by dividing the total value of the data (in this case, by adding together the ages of all students, or 4,183) by the number of cases (in this case the number of students, or 89).
[b] The standard deviation (SD) measures the spread of the data. The higher the SD, the more different from one another the participants will be.
[c] The median is the middle value when data is arranged in rank order, or from smallest to largest. In this case, the median age would be the age of the 55th oldest of the 89 students.
[d] n refers to the number in each category described. In this case, n=63 describes how 63 students were female.

the W2R course, there were 44 completed questionnaires. Twenty-five students (57%) undertook the course in its face-to-face format and 19 students (43%) did so online. For T3, i.e. three-month follow-up after the completion of the W2R course, there were 18 completed questionnaires (10 from those who did the course online).

Mental wellbeing measures

At baseline, the mean mental wellbeing (WEMWBS) scores across all students (n=89) was 35.59 (SD 9.67). Students' WEMWBS scores ranged between 14 and 65. Upon further examination, the mean WEMWBS score of male students was 34.65 (SD 8.09), and that of female students 35.98 (SD 1.29). Mental wellbeing scores were not of significant[e] difference between males and females (see Figure 2). Similarly, age or employment status (see Figures 2 and 3) had no significant effects on the students' baseline WEMWBS scores. This means that at cohort level across all students, the study did not find any significant difference based on gender, age, or employment status. The mental wellbeing scores at T1, derived from 71 students, were similar to that of the baseline: mean WEMWBS was 35.03 (SD 8.54).

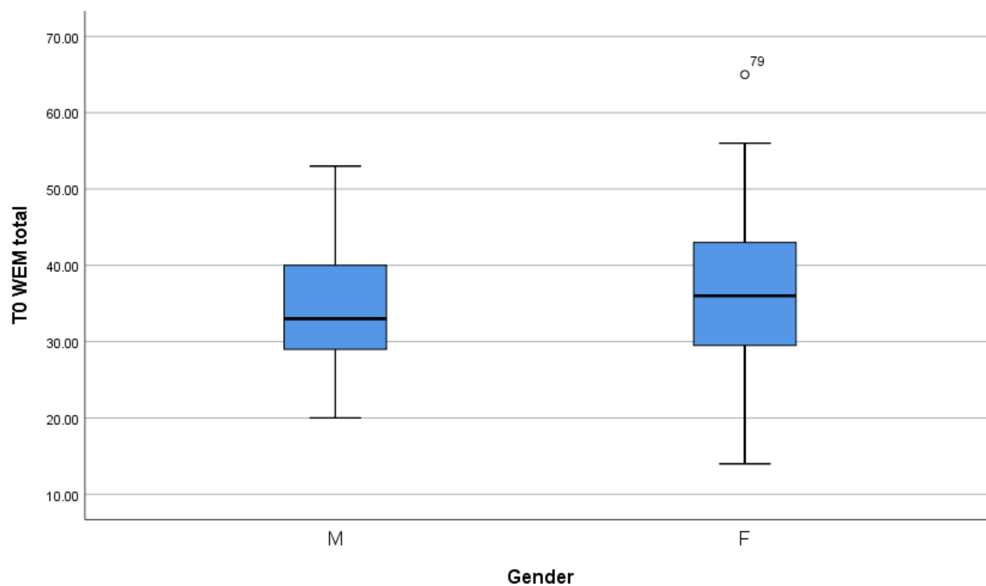


Figure 3 Box plot illustrating the baseline WEMWBS scores of male and female students

[e] In statistics, the term *significant* or *significant difference* refers to differences which can be calculated to have a p-value of 0.05 or less. See footnote i for further explanation.

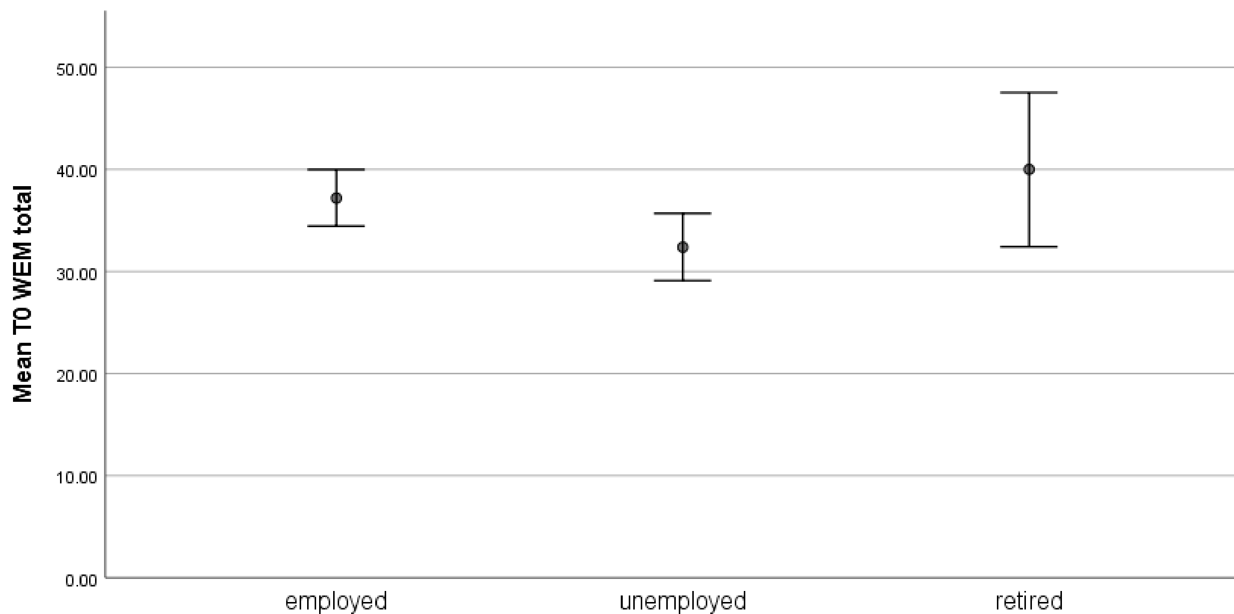


Figure 4 Scatter mean plot illustrating the baseline WEMWBS scores of students with different employment statuses

The research compared the students' WEMWBS scores, which are significantly lower than the average WEMWBS score (49.9, SD 10.8) of the general population as reported in the Health Survey England in 2016 (calculated from a sample of 6799 individuals, 51.3% women, from published data of HSE, 2016). An independent-samples t-test[f] showed that the mean difference of -14.31 in WEMWBS scores was statistically significant between our student sample and the HSE sample (t = -13.85[g], 95% confidence interval (CI) -16.34 to -12.29[h], p<0.001[i]). This difference is nearly five times the mean clinically important difference (MCID) of 3 points on WEMWBS (44). Of note, the WEMWBS was designed to measure positive mental wellbeing, rather than to assess for presence of a mental illness. Nonetheless, the WEMWBS has been compared to the Centre for Epidemiological Studies Depression Scale (CES-D), a measure of depression (52), which suggests that a WEMWBS score of 40 or more indicates a high risk of depression.

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[f] A t-test measures the difference between two sets of data by comparing their mean and standard deviation. In this case, the t-test compares the wellbeing scores of RiM students with those of the general population.
[g] In t-tests, t measures the difference between datasets. The higher the t value (whether positive or negative), the greater the difference between datasets. In this case, the high negative t value indicates that RiM students had significantly lower levels of wellbeing than the general population.
[h] 95% confidence intervals (CI) are the lower and upper limits within which the statistic produced will be accurate 95% of the time. In this case, the t value's figure of -13.85 has 95% CIs of -16.34 to -12.29, meaning that the reader can be 95% certain that the true result will lie between -16.35 and -12.29.
[i] The p-value is the probability that any given statistic will have occurred by chance, thereby yielding no meaningful deduction. In this case, p<0.001 means that there is less than a 0.001 probability that the t-value occurred by chance.

At T2, i.e. end of the WTR course, students' WEMWBS ranged from 27 to 57 and their average WEMWBS score was 44.27 (SD 9.45). Male and female students' mental wellbeing scores are similar: male mean WEMWBS was 46.11 (SD 11.25); female 43.80 (SD 9.05). While these figures are still below that of the population norms, they are statistically significantly higher than those measured prior to students undertaking the course (mean difference = 8.88, 95% CI 4.70 to 12.78, p<0.001). The increase in WEMWBS score of 8.88 points was nearing 3 MCIDs, indicating a substantial improvement in mental wellbeing among the students through the course.

At T3, i.e. three months post-completion of the W2R course, students' WEMWBS scores averaged 43.09 (SD 10.89), ranging from 25 to 57. There was hardly any difference between the scores reported by male (mean 43.20, SD 12.81) and female (mean 42.92, SD 10.64) students. The gain made by students in WEMWBS scores previously was found to be sustained in the follow-up, as T3 and T2 WEMWBS scores were of no statistically significant difference (mean difference = 1.67, 95% CI -7.06 to 3.73, p=0.52). Figures 4 and 5 illustrate the changes in WEMWBS scores by gender and by age grouped into three categories (under 34, 35-54, and 55 or over), across the four time points.

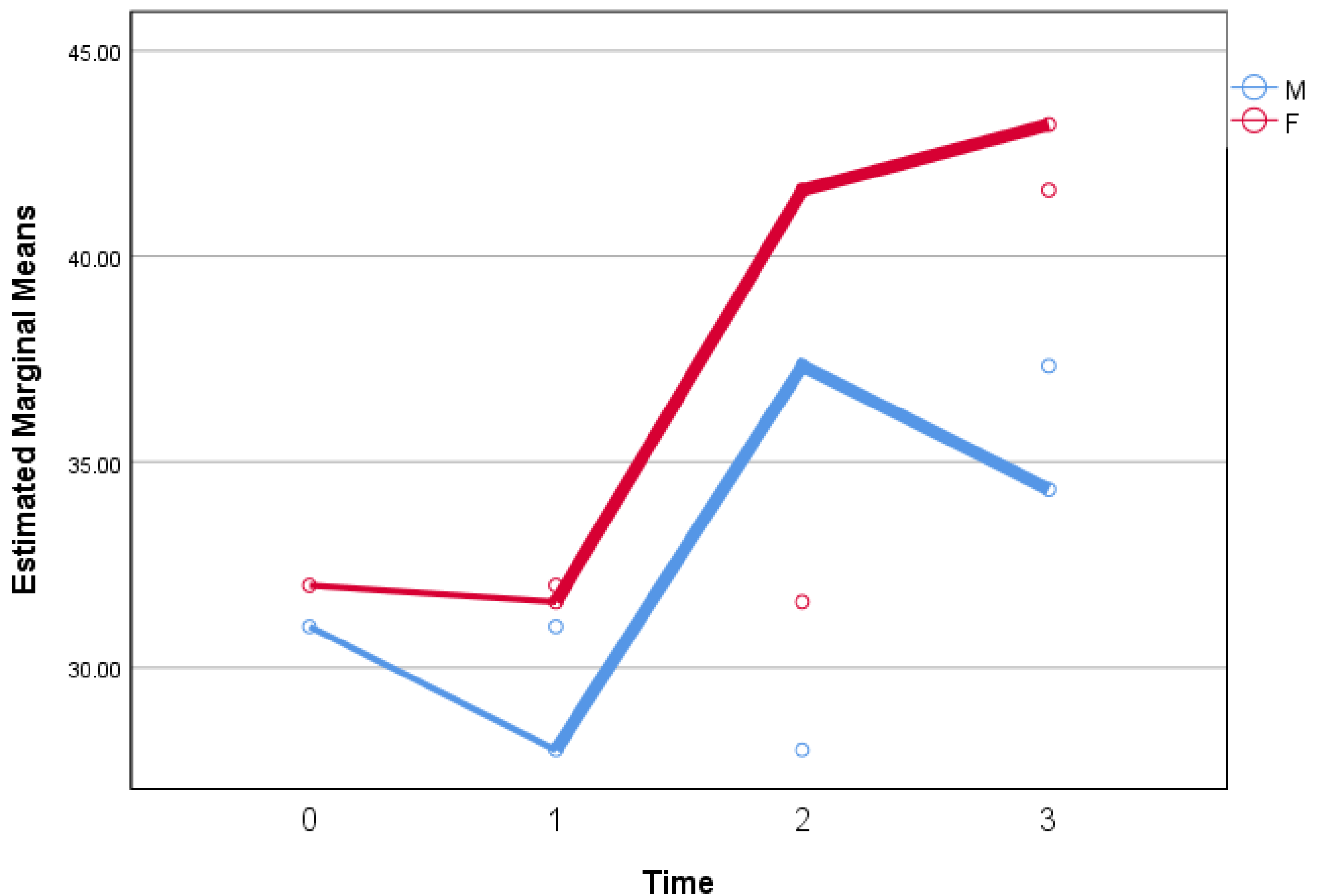


Figure 5 Estimated marginal means of WEMWBS scores by gender across four time points

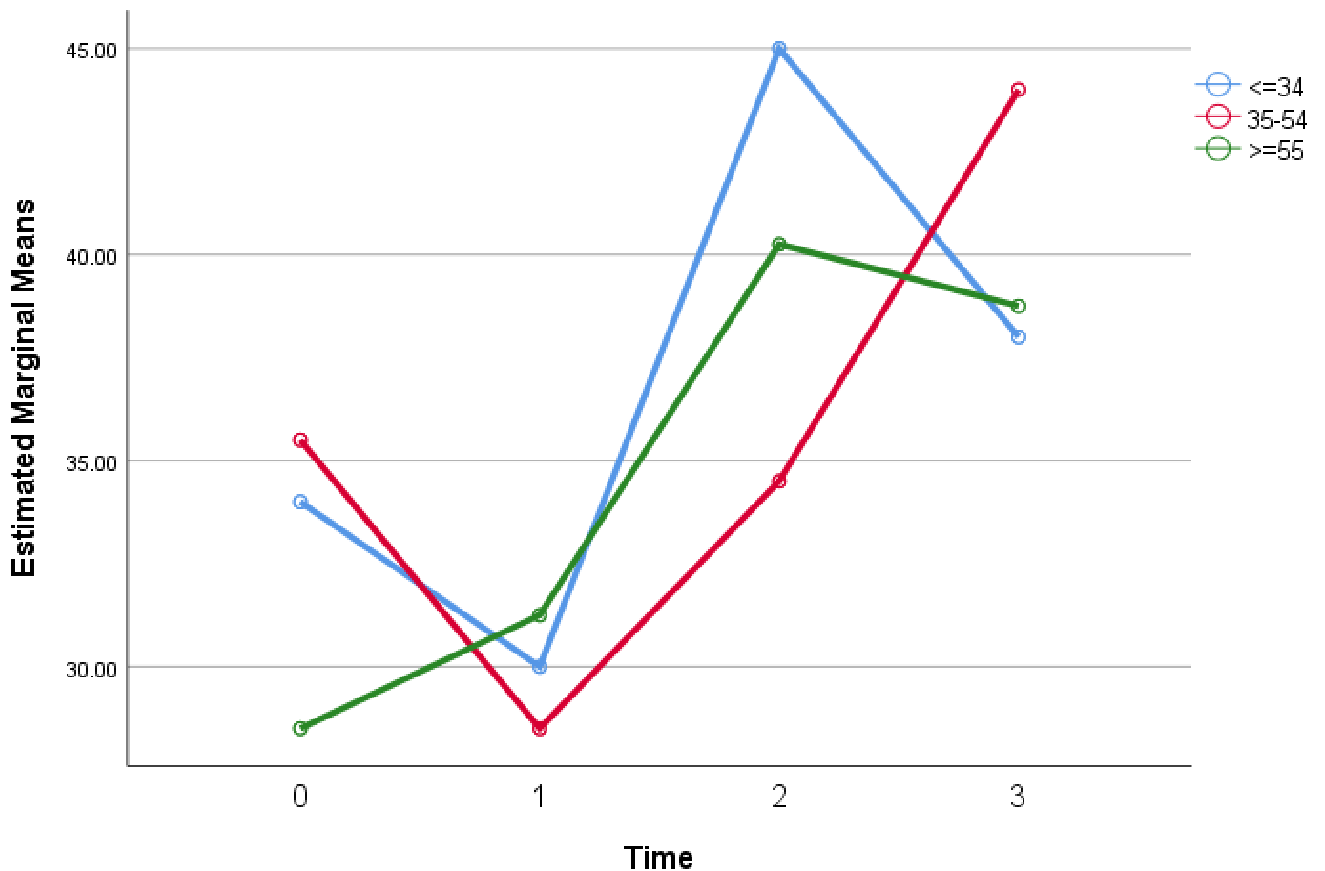


Figure 6 Estimated marginal means of WEMWBS scores by age across four time points

Interpretation of the results on WEMWBS

Overall, mental wellbeing as measured by WEMWBS among the students at baseline was poor. Although as a Recovery College RiM would not define itself as a mental health service, its main sources of students were GP surgeries and community mental health services. These may reflect that its students are primarily individuals with pre-existing mental healthcare needs, and some were using primary and secondary services prior to and/or concurrently with attending RiM.

The RiM courses have brought significant positive changes in students' mental wellbeing, at least to those who completed the WTR course. The improvement in students' mental wellbeing was sustained at three-month follow-up. As progression from Steps 1, 2, and 3 is entirely voluntary and RiM also directs its students to other community-based resources, such as voluntary work opportunities, it is not possible to speculate the reasons behind the reduction of student numbers across time points.

Subjective evaluation of personal goal achievement

At the beginning of the courses (either Bitesize or WTR), 73 students completed the personal goal achievement question. The scores ranged from 0 (not at all) to 10 (completely), with mean score at 3.07 (SD 2.16) and the median score was 3.00. These scores were similar among male or female students, and across age categories and employment status, indicating they felt they had a long way to go in achieving their goal.

Some of the wide-ranging personal goals the students set for themselves included:

> Gain confidence and recover my mental health, think clearly, not rushing into decisions, be kinder to myself, appreciate life
>
> Feel better about myself and stop over-thinking and also be back to my old smiley happy self again
>
> To not be overwhelmed by stress, to be able to relax, to like myself
>
> To lower my daily anxiety level
>
> To feel it's okay to be me and be comfortable with my emotions
>
> Improve my self-confidence
>
> Overcome my stress
>
> To feel I am capable in life and worthwhile and less anxious all the time
>
> Be able to talk and not bottle things up… [to avoid] the spring has been wound up so tight, and the spring breaks and explodes

At T2, i.e. end of the WTR course, 38 students completed the personal goal question. For male students (n=8), the mean score was 5.63 (SD 2.07) and the median score was 5.50. For female students (n=30), the mean score was 5.03 (SD 2.08) and the median was 5.07.

At T3, i.e. three months post-completing the course, 16 students, 5 males and 11 females, completed this question. The mean and median scores among the male students were 4.20 (SD 2.49) and 4.00 and for females were 5.18 (SD 2.71) and 6.00 respectively.

Interpretation of the results on the personal goal questionnaire

This question aimed to encourage the students to consider a goal they would like to achieve through their participation in the RiM courses. This was never designed as a validated questionnaire and so it would not be appropriate to apply much statistical analysis on the data. Looking at the selection of goals set by the students, these reflect the students' aspirations in developing themselves and their interpersonal relationships, and in resolving mental health difficulties which had been preventing them from living their lives to the full.

Chapter 6 Enjoying the Ride?

How I found the bus, and how I joined the journey

Six students were interviewed: five female and one male, and with ages ranging from early twenties to recent retirement. In accordance with the Recovery College ethos of not focusing upon mental health histories or diagnoses, students were not asked to disclose this information, though some nevertheless did. Nancy had been a student since 2018, and Sam since 2017, and the remaining four (Carrie, Heidi, Joe, and Julia) joined RiM during the Covid-19 pandemic in 2020 or 2021. Carrie and Joe had participated in the socially distanced Welcome to Recovery course run at the local council chambers in the autumn of 2020, and Heidi and Julia had participated in online Welcome to Recovery courses delivered via Microsoft Teams meetings. All four were then either taking or had recently completed Five Ways to Wellbeing to join Nancy and Sam on the Stage 3 courses.

How I discovered RiM

Four of the students described how they had first heard about RiM. Nancy had been put in touch by the CMHT, and Julia by her GP. Carrie had seen an advertisement for RiM on the screen at her GP surgery. Joe's daughter had seen an ad in a local newsletter, and had thought that he might benefit:

> I'm on this course because of the feedback I received from our eldest daughter and she said, "*Dad sometimes when we are chatting I don't feel like you're there*" because I'm thinking about all this other stuff (Joe)

How I felt at my first sessions

For those who had started RiM prior to Covid (Nancy and Sam), the RiM journey had begun with the one-off introductory session which was replaced during Covid by the Bitesize video. Whereas Carrie had been able to progress to a face-to-face Welcome to Recovery, albeit in a socially distanced manner that had made it feel very different to Nancy and Sam's, Heidi, Joe, and Julia had needed to undertake Welcome to Recovery online. Despite these very different paths towards their initial bus journey, students described strikingly similar feelings as they boarded; at first they felt apprehensive, nervous, and reluctant to speak, but then they felt included, listened to, and encouraged:

> Yes I was nervous and a bit of anxiety [but]… it was great talking to people (Sam)

> I remember my first session and I was scared stiff about meeting these new people. I was doing something I knew I had to show people I can do this, I want help… [afterwards] I'd learned about hope. That there are always seems to be some sort of light at the end of the tunnel (Nancy)

> Obviously it was quite a new experience for the people running the course as well and the fact that people were spread out and some of the group activities had to change and things like that, but what was quite nice was that it was very adaptive. The setup of the room to me had a real connection with work which was why I was off sick so I asked… if we could just rotate 90 degrees… what's nice is that you make a suggestion and it's listened to and actioned upon. We were spread out all facing the same way at the beginning and then we went into a horseshoe which seemed a bit more cohesive as a group (Carrie)

The toolbox that RiM provided, and the tools that RiM helped me find to fill it

In describing the contents of their personal toolkits, students distinguished between the skills that they had been taught within RiM classes and the wellbeing strategies which RiM had empowered them to discover and to develop for themselves. For some students, these skills and strategies were things that had learned about in the past from counsellors, therapists, and other forms of mental health treatment they had received. These students were grateful to RiM for the reminder, the reinforcement, and the practical support which RiM provided for them to practice and to develop these skills and strategies. For other students, RiM was completely different from anything they had ever tried before, and helped them as nothing else had.

The skills I learned from RiM

Students described the most valuable skills as mindfulness, being aware of one's surroundings, creativity, and being with others. These skills were explicitly taught in the Stage 2 Welcome to Recovery and Stage 3 Five Ways to Wellbeing courses, and then combined with one another and woven into the other Stage 3 courses such as the art group and Coffee Catch-Up:

> I always think when I go out for a walk… after I've done a[n online RiM] coffee morning, whatever we've discussed in that session I find I think about and gives me good thinking time. It makes me more aware. One time we were talking about signs of spring… it made me think a little bit more and someone mentioned about things in the hedgerow, so I was looking there. It gives you more of a mindfulness time (Carrie)

> It's been the different strategies to cope with my own mental health problems. It helps you find different ways of dealing with it. It encourages you to try new things within that timeframe. The art… really helps and… having that help and support helps you stay in the moment. You're busy concentrating on doing your piece of artwork, sewing, or knitting or painting but you're zoning in on it and you're forgetting about everything else in the outside world (Nancy)

Students described becoming increasingly confident in pursuing these skills independently. Nancy had progressed from art and reading sessions at RiM to joining painting and theatre groups within the local community. Carrie had used the support of RiM to explore nearby volunteering opportunities before joining a less local charity whose activities better suited her own skills and interests.

The strategies I discovered for myself

Students used the skills taught and learned in the RiM classes, and the toolbox metaphor around which these were structured, to develop increasingly personalised strategies to improve their longer-term wellbeing and resilience. Students valued the ways in which RiM had nurtured their creative, cultural, and outdoor interests, supporting them to find the confidence and take the initiative to develop these interests further:

> You can get completely lost in your painting and not have to think about anything else but that painting. It was very helpful to me that last year I sadly lost one of my lovely cats, died unexpectedly and my husband suggested that we create a flowerbed in the corner of our flowerbed, what we called Clyde's

> Corner. I thought "yes". We had some wooden plant stakes and I thought, "Right, I'm going to get my paints out and I'm going to paint the words Clyde's Corner and do little pictures of paw prints, cats." He was a little black cat and flowers. It was so therapeutic. It really helped. Then I put them out and we decided that we would make sure there would always be flowers in that corner and there has been ever since, even in the winter. That really helped me (Sam)
>
> The Wellness Recovery Action Plan [course delivered in 2019], that inspired me in taking up tennis again, which was something that I used to do, because you learned to take up new things as well as trying to take up old things that you used to do to help your mental health recovery. By taking that WRAP course, I took up tennis with Sport in Mind and met some famous people on the tennis circuit. If RiM hadn't been there, I wouldn't have gone to Sport in Mind and taken up tennis again. I wouldn't have signed up to Newbury Tennis Club and I certainly wouldn't have met the double Australian Open and Wimbledon champion (Nancy)

RiM had not only taught valuable recovery skills, but had empowered students to develop their own strategies for managing their wellbeing.

How RiM reinforced what I'd learned from other mental health services
Four of the students spoke of having received help with their mental health before finding RiM. All drew parallels between their previous experiences and what they had learned from RiM.

Six months prior to joining RiM, Carrie had attended a course at work which had covered the same material as *Five Ways to Wellbeing*. She described the consolidation of this learning at RiM as having enhanced her learning because she had joined RiM once she had reached the point of becoming able to engage with the skills being taught:

> I would say I hit rock bottom [on that first work course in January 2020] … I was making connections and things were coming out and all that sort of stuff. Although I gained an awful lot… my head probably wasn't in the best place to absorb it all… but then by the time I did Five Ways it was September so I had done a lot of online stuff myself and research myself and got a therapist. So by the time I did Five Ways I was in a much better place to really consolidate. For me a lot of it was consolidation… By me doing what essentially was an enhancement of what I had already done… [there] were different things I took from it because I was in a different place in my head (Carrie)

Both Julia and Heidi had previously learned the material taught in RiM from their own research or through individual therapy. Heidi described how revisiting this learning in the classroom-based setting of RiM had enabled her to learn from the commonalities of experience described by fellow students:

> We did personal boundaries/personal responsibilities and that I could link to my sessions with my therapist because it was like my values and the choices that I take and value, so it was quite interesting doing that again because a lot of people have similar boundaries or similar choices/values (Heidi)

The learning process, then, proved as valuable as the course content. Repetition, consolidation, and reinforcement were only ever an asset.

How RiM is different

Even for those students who had received significant amounts of mental health support in the past, much of what RiM taught was nevertheless very new:

> The actual course content, the RiM initial course that I started made me look at things that I hadn't really thought of before I think… it's great because you learn new things. I've seen numerous therapists but there are still things that you pick up on, so it's nice. I have to say that the course that I've just finished, I'm on the fourth week, we have the fifth week coming, which is the Five Ways to Wellbeing, and like I said given the amount of therapy that I have done, I have never been told about the Five Ways (Heidi)

More specifically, Julia and Nancy both described how RiM had introduced them to the mental health benefits of volunteering and adult learning, things which after many years of mental ill-health they had previously regarded as unsuitable or inaccessible to them.

For students who had never considered or sought help with their mental health before joining RiM, everything they were taught had been new. Joe described how exhilarated he felt by everything he was learning:

> We all take exercise to be physically fit but we don't necessarily do any exercises to be thoughtfully fit. There was something I was listening to on your website the other day and there's only about 25% of people come out of childhood having those skills, that's only 1 in 4, 25%, three quarters of people haven't learned those skills that would help them throughout the rest of their lives.

Whatever their stage in their personal recovery journeys, students were leaning new things from RiM.

The support I received, from crew and passengers alike

The skills which RiM taught and the strategies which RiM facilitated formed only part of the overall travel experience. Equally as important to students – and in some cases, even more important to them – was the support that they received from crew and passengers alike. As they first described this, students spoke about the care, guidance, and inspiration they had received from the various individuals delivering and participating in the courses, mentioning Angela most frequently, but also other peer trainers, students, and staff. As they reflected at greater depth upon their experiences, however, students came to describe the overall process of being part of the group as more supportive than any of its constituent elements. The atmosphere of mutual peer support helped the group to develop and operationalise their learning. The teamwork between facilitators helped students to understand the value of being with others.

Angela inspired me

All six students volunteered their appreciation of Angela:

> Angela, yes. It's very helpful to have Angela… her experience and her journey and her commitment to what she does was the most inspiring I have to say because it was not professional. I think she was a major pull to the course (Julia)

> When I saw Angela for the first time and I heard her experience and mental health challenges, it really inspired me and from her perspective... She's helped a lot of people through her own experience and the realisation that you can

> achieve something because people can go years and years without achieving anything because they're still stuck in that same position (Nancy)

> I think through therapy type of things I've done, if my therapist has suffered herself you can always relate a bit and I think it's nice being able to do that. I've got a broken shoulder at the moment but my physio that I'm doing with work broke her humerus two years ago and actually she can relate to things. It's so much easier to talk to someone who you know can relate… Angela was brilliant in the first course and she was really enlightening giving her own experiences so actually it made people who joined the group be able to think, well okay, if the therapist running the course is going to share their experiences, there's no reason to feel judged about giving your own experiences (Heidi)

Students valued Angela because she demonstrated to them the reality and possibility of mental health recovery, and because she created for RiM an atmosphere within which openness was safe and lived experience was valued.

Being with others who'd been through similar showed me that some people do understand

Although they singled Angela out, students also described the great extent to which they valued the shared experiences of other peer trainers and fellow students:

> When you started talking to people you realised that they were there for whatever reason, we all had similar backgrounds or mental health problems. It was great… people like me (Sam)

> Some of my friends know about my issues and some don't but there's only really one person that knows and understands but most of them just don't get it so you feel a bit separated from those people sometimes. Whereas the people at RiM do get it and that's quite a big difference (Carrie)

Within the RiM sessions, students no longer felt the isolation and sense of alienation which had previously characterised their experience of living with mental health struggles. Heidi described how this led to her being treated by fellow students more tolerantly than she had expected:

> I was very open from day one about my head injury and apologised if I repeat myself or if I don't sit still for terribly long because I'm not very good at sitting

> down for long periods. Everyone's completely understanding about it all and it was nice (Heidi)

Julia described how the mutual understanding which existed between students meant that group members listened to one another more attentively, engaged with one another's recovery journeys more intently, and took collective responsibility for the group process:

> Being able to listen… I've never done therapy in a group like that in terms of recovery… you have this group and it's a kind of commitment and if you don't show up then what does it say to the rest of the group? It was a new thing for me to be part of a group rather than having individual sessions. I think that is very valuable indeed. I like that a lot, having other people involved in the process… the responsibility of being present, of helping others so it's more about what you can give, contribute, that I thought was valuable (Julia)

The atmosphere of mutual peer support helped us to develop and to operationalise our learning

This intensity and mutuality of peer support not only benefitted the collective group process but strengthened the ability of the group to learn collaboratively and to put their learning into practice together:

> The discussion always opened things up and not always in the directions I was anticipating, and I think that was a huge advantage because I think each of us could contribute different thoughts and it actually extended your understanding much more than if it had just been me there or whatever and I thought I was able to add comments that might have been interesting to other people… One of the other attendees on the course said, "This is a really good book, 10 things you can learn from Aristotle." I actually ordered it on the strength of the recommendation and read it. There's a lot of really good stuff in there and it does mention the way to a good life is by helping others (Joe)

Students described how spending time with one another helped them to remember, explore, consolidate, and practise the skills they were learning and the strategies they were developing:

> I think it's maintaining a connection really. When I first became unwell I thought I would be better in a couple of months or whatever and as time has gone on I really understand that the recovery is a really slow process that you do need to work at. It's not just a case of attending the welcome course and that's it, you're fixed and ready to go. For me I like that, almost like a slow drip feed of

> information and connection to be fair. Just sort of a top up. Information. When I did the first course in the council chambers then I did the other one online, one of the people was the same but then there were a whole group of new people and then when I've done the Walk and Talks and the coffee mornings, occasionally I would see someone I had met physically but then there's quite a few people who are on there that I've not met in person so it's nice to hear other people's inputs and ideas and sometimes you will think, they might talk about a subject you haven't got a lot of interest in but it's still interesting to hear. And someone will say something, and if is something you are interested in and it will give you an idea to do something or something to think about (Carrie)

The cohesion of the group meant that students felt motivated to persevere with the recovery journey, even when life felt difficult:

> You're all wanting the same thing. They're understanding. You realise that you've got to do something for yourself to get yourself out of it… I felt very, very nervous when my nurse said that I had been discharged from Early Intervention [in Psychosis] but I knew I still had RiM there and I'm nowhere near ready to give it up. They're [also] wanting to manage their own mental health and they want to try and get themselves better, maybe not better but more of a way of learning how to cope and see things in different ways and try different things (Nancy)

> It's not about something that works once you've done it, it's the fact that you have to do it every day and you have to do it constantly. That's what RiM reminded me and helped me put in place again. There isn't a choice really if you want to be well mentally (Julia)

The teamwork between facilitators helped us to understand the value of being with others

Although students described Angela's role as most memorable and spoke of feeling most supported by one another, they nevertheless remained aware of the staff team:

> I remember all the leaders. There wasn't just one, they all contributed their strengths and their experience. So I remember being very impressed by all of them. I thought these were good, caring people that I was happy to go to any future courses with them leading them (Sam)

Students commented upon the collaboration and teamwork they observed with the RiM leadership, observing how Angela's lived experience was accorded parity of authority and credibility with the information provided by the Occupational Therapists:

> Cath is great because she's very open to… she'll always back Angela up on what she has said and how she dealt with it and so that's a really positive thing... It's not all about professionals as such, it's personal experience as well (Heidi)

> Angela was very good at giving examples and some pithy phrases and Cath and Fiona too were excellent too at going through and explaining some of the different aspects (Joe)

This teamwork modelled and reinforced for students what RiM was teaching them about the value of being with others and of being a group:

> I'm the youngest in the group but actually that doesn't make any difference, and everyone is really supportive and we ask Helen for one another's email addresses at the end of the course so actually we have communicated and it's nice to be able to do that I think… we've all been doing stuff together so when you think about it like that, you share quite a lot of information with complete strangers really (Heidi)

> I remember this tree with little men, and you had to say which little man you identified with and why. As well as being fun it made you really think about it and everyone had a different little man and different reasons for where it was in the tree. That was quite good… I went for the one where someone was helping you up with their hand you know. Someone else was standing there holding you and you were standing on their hand, being lifted up into the tree (Sam)

The Covid diversions, and how we handled them

All of the students found Covid difficult. Carrie and Julia had always had significant caring responsibilities, and lockdown meant that both were undertaking additional and additionally challenging care tasks, and becoming increasingly more isolated in doing so. Heidi had left friends and work to move to into the Newbury area during lockdown because of a life-changing injury requiring a level of care that she could only receive back at home with her parents. Covid had disrupted Joe's plans to relocate away from the Newbury area, and he had already distanced himself from local activities in preparation for this move. Sam had been prevented by social distancing regulations from saying goodbye to her frail and elderly mother, who had passed away during the pandemic. Students also struggled with

the lack of structure that workplaces and leisure facilities had previously provided, struggled with being unable to see or socialise with family members and friends, and felt anxious about their loved ones becoming ill with or dying from Covid.

Nevertheless, students described their appreciation of how RiM had adapted to regulations and remained active throughout the lockdown, and spoke positively about how much they had benefitted from the local connectedness and support that RiM had provided.

Online classes

Heidi and Joe, whose first RiM courses had been entirely on Teams, had long found online interactions comfortable and effective. Both observed that Helen and the RiM leadership had worked hard to facilitate and maintain what felt like a safe and well-boundaried space, and that the pre-existing teamwork had enabled the transition:

> The team were very professional, and I found Zoom meetings to be an advantage… I mean I'm sitting here with the screen, you can just about see my head and you miss a lot of body language and stuff like that obviously (Joe)

Julia described more ambivalence towards online courses:

> It could have been two ways. Either I could have said, do you know what I can't do it today and not go at all or I said okay, I've got to go, I've made a commitment, it's important to go. And the contact with other people, is forced physical contact, you kind of have to get out of yourself a bit more. So if I had chosen to go, maybe it would have taken me out of my negativity more than the online process. With the online process you can actually switch off, you're still there but you can switch off completely… Because you are not accountable basically. No-one can see what you're doing if you're doing something else, if you're writing, no-one sees but you're still there (Julia)

Despite these reservations, however, Julia was committed to continuing online courses for as long as lockdown restrictions required. Carrie, Nancy, and Sam took a similarly pragmatic stance. Each agreed that, whereas online sessions probably cannot fully replicate the collective experience of a face-to-face group activity, RiM's move online had been necessary, well managed, and beneficial:

> I'm glad I did go online because although it's not perhaps as good, there is no reason why I couldn't and that's the way the world was going, and it made sense to continue as opposed to just completely stop. Some other activities I'm involved with just completely stopped, mainly sporting type stuff, but that complete cut-off was quite a worrying time really for me personally so to have it continue but in a different format I thought was very beneficial (Carrie)

Students particularly appreciated the online Coffee Catch-Up sessions, the opportunity they provided for conversation, and the connectedness they offered to those who could not attend the socially distanced outdoor sessions:

> Coffee mornings, they were good. Coffee Catch-Ups. It was good to see Fiona because I hadn't seen her for quite a while… it was lovely seeing her at these Coffee Catch-Ups. I don't see why [we shouldn't keep them going after Covid]. It's just lovely to… maybe you won't need to do it so much but I think it would be nice (Sam)

Socially distanced outdoor activities

Students spoke equally positively about the socially distanced outdoor activities. Carrie and Nancy described the continuity they provided in enabling students to maintain face-to-face relationships with one another. However, in the same way that Sam described the accessibility benefits of online sessions, Carrie was concerned that students should not feel excluded by the perceived physical demands of what was then called Walk and Talk:

> What I have been impressed by is that if you make a suggestion it is listened to. The first time I went to the Walk and Talk I didn't know quite how to dress as I didn't know how far we would be walking and stuff like that and… I know one of the ladies on my Welcome course specifically didn't go to those because she was worried about the walking so in some ways that precluded her from… well, it didn't but she thought it did. I said it would be better to be renamed and they did – I just made a suggestion and then I saw on the calendar it's now Ponder and Wander and I thought that's really nice that someone is listening (Carrie).

Newsletters

All of the students reported that they had read and benefitted from the weekly newsletters they have received during Covid. Sam particularly valued these, not only for their regularity and content but for the opportunity they provided her to contribute:

> On Tuesday this week I went onto the Coffee Catch-Up and I was telling them that actually I felt that RiM and all the support I was getting even during Covid with all the newsletters and everything, that I was resilient. The newsletters have been really nice when we were in full lockdown last year when the online things hadn't really taken off. Getting those were great. I contributed to the students' corner a few times and that was so lovely, seeing my pictures or the tricks that you taught me to do (Sam)

RiM helped me to feel connected to the local community

Beyond the sense of student community being developed by online and socially distanced outdoor activities, students described how RiM had helped them to feel more connected to the natural environment and with the people and activities present in their local area. Several students described how they had used the skills, strategies and social support provided to feel sufficiently confident to pursue those social opportunities less restricted by the pandemic:

> I realised that I do some running but I'm always running on my own so I picked up on the idea of exercise with other people is something that I really ought to be involved in more. I've actually looked into the Sport in Mind and next week I'm going into Newbury to kick a football for a little while and I think that will be fun (Joe)

Students found this wider sense of connectedness and most holistic sense of community of particular value because of how Covid had disrupted their lives. Sam described how the socially distanced Ponder and Wander sessions had helped her rediscover her local interests:

I had interests before I was unwell but I thought I couldn't be bothered, what's the point, like bird watching, photography. I love them again. I come back to them and they are very important to me now… I appreciate nature and we've had time to appreciate it this last year. We've had time to go for walks and to get out, birds, colour in nature – it's brilliant. I had lost that for quite a while until I came back and I think RiM has reawakened all that in me (Sam)

The future, and where I'd like RiM to travel next

At each interview, students were invited to provide RiM with their feedback: what hadn't worked for them, what hadn't they enjoyed, and what did they think RiM could do better, travelling out of the Covid pandemic? Students responded to this question primarily by talking about how they felt that RiM was fantastic already, that nothing had been unhelpful, and that all RiM needed to do was to continue and to expand. However, some offered constructive suggestions towards how RiM might expand.

It's fantastic already, but you need a bigger bus

Students spoke unanimously and effusively about the value of RiM:

> Yes, massively [beneficial]. The anxiety is much better. It still comes up, like I had this weekend for no reason, no idea why… but it's a hundred times better than it was in January (Julia)
>
> Even Mum and Dad have said that I'm in a better state of mind and I think the combination of what I'm doing outside of the course and the course is a great help. Because it's something you look forward to and you know you're going to benefit from it, it does lift your mood (Heidi)
> it's just been brilliant, everything, it's just done so much for me and I know it has for a lot of other people as well, people I've met on the courses (Sam)
>
> I would like to say that RiM has helped me in more ways that I could ever imagine, and I would give them 5 stars, 10 stars, 20 stars. You can understand what good it does for people. If RiM wasn't there… like Angela said, before she started there wasn't anything and I think she's done a really good and valuable,

> worthwhile thing. I would love to help anybody that wanted to get better, but they thought it was a struggle. It proves that you can with the right help (Nancy)

All hoped that RiM would continue to develop its activities and to expand further:

> I don't think it's necessarily improve, but I think there are certainly tonnes more courses they can do (Nancy)

A few other routes you maybe could try

Both Nancy and Heidi reflected upon how RiM might respond to the challenge of the anxiety which the pandemic had caused or exacerbated for many people, suggesting targeted anxiety management classes and smaller numbers in some classrooms. Carrie and Joe were keen that RiM should support people struggling with their return to workplaces, suggesting that RiM expand to include evening as well as daytime sessions, and continue with online courses. Nancy and Sam agreed that online and outdoor courses should continue, not only because they had improved accessibility but because they were effective and enjoyable.

Carrie and Joe expressed concern about the ongoing challenge of how mental health stigma appears to deter people of working age from seeking help, and Joe suggested that RiM might partner with a prominent local employer to address this. Other suggestions included assertiveness classes, and one-to-one introductory sessions prior to joining the classes.

All of the students were keen for RiM to continue along its journey.

In June 2021 Recovery in Mind celebrated its fifth birthday.

Chapter 7 Meeting Our Travellers

The students

Heidi

Heidi works with racehorses, but is currently off work following a series of riding accidents. One of her physiotherapists once had a similar injury to hers, and it was hearing about his experience that provided her with an introduction to the benefits of peer support. Heidi has struggled with her mental health for some time, and has had several therapists, one of whom, due to Covid, she has seen entirely on Zoom. Whereas she has always found therapy helpful, she has found that Recovery in Mind has taught her a lot of things that therapy hasn't, particular in terms of the practical skills for wellbeing.

So far, Heidi has been the youngest student in both of the online courses she has attended. This doesn't matter to her at all – instead, she has learned a lot from their wisdom and life experience – but she does worry that some of the older students who won't have grown up with computers may have found the move to online classes difficult. She has particularly benefitted from how confidently Angela and the peer trainers always speak about the problems they've had – not just for the learning and inspiration of listening to them, but because their openness makes her feel that she herself can say anything without being judged. This feeling of acceptance is important to her, because she worries that her head injury might have affected her ability to remember what she has said already.

Heidi has found lockdown extremely difficult, especially because it coincided with her accident. She has always been a very sociable person, and her injury had left her unable to drive to meet people outdoors. Before lockdown, she had relied upon the sunshine abroad to help her mental state through each winter, and she struggled with not being able to travel last winter. However, Recovery in Mind has really helped her to cope, because the morning sessions have helped her to get going for the day. She is writing in her journal a lot at the moment, which is something else she learned from the classes.

It was Heidi's birthday recently, and she felt hugely touched that the class remembered and wanted to celebrate it with her during the session. Now that the lockdown is easing, she is beginning to meet other students for walks and coffees, which is something she greatly enjoys. Heidi suggests that, as Recovery in Mind returns to face-to-face classes, the group numbers are kept small initially, so that students do not find the transition too overwhelming.

At T0, Heidi scored 34 on WEMWBS, and she put 4 for where she was with the goal she wanted to achieve when she first joined the courses. At the end of the WTR course, her WEMWBS score was 46, and she rated herself as 6 in terms of achieving her goal. At three-month follow-up, Heidi's WEMWBS score and goal achievement level remained similar to the earlier time point (see Figure 6).

Joe

Joe is a recently retired geologist who is fond of the natural world and deeply committed to his wife and children. Joe first realised that he might benefit from help with his thoughts and moods during the first lockdown when one of daughters told him that she sometimes felt that he wasn't really with her when she was talking to him. Joe reflected privately upon this and became concerned that, although he had always provided his children with a great deal of practical support, he may not have offered them as much emotional support. This same daughter then heard about Recovery in Mind, and suggested to Joe that he sign up for a course.

Joe contacted Helen, whom he found hugely helpful in explaining how Recovery in Mind works. He joined a socially distanced Welcome to Recovery course in Newbury in September 2020, and then an online Five Ways to Wellbeing in November 2020. He liked being in the group, and appreciated the honest wisdom of Angela, the professionalism of staff, and the advice and book recommendations of peer trainers and other students. Joe found the courses beneficial because they taught him to understand and to take control of his difficult thoughts, and that this improved his mood. He has found mindfulness an especially useful skill to have learned.

Joe has found the Covid pandemic stressful because of the life plans that it had disrupted, and because of the differences of opinion within his family and social circle that it had exposed. However, he believes that the increased use of online technologies has been a positive thing, and has many ideas for how Recovery in Mind could deliver more virtual courses. He is concerned about how, even in this day and age, some working-age people still worry that getting involved with organisations such as Recovery in Mind will harm their career prospects. He would love to encourage local employers to partner with Recovery in Mind to encourage more people to seek help early.

When Joe first joined Recovery in Mind, his WEMWBS score was 51 and he rated himself as 6 in terms of reaching his personal goal. By the time Joe finished the Welcome to Recovery course, he scored 67 on WEMWBS and he placed himself on 9 (out of 10) in terms of achieving his goal. At 3-month follow-up, Joe's WEMWBS score was 56 and goal achievement level was 8 (See Figure 6 for Joe's WEMWBS score progress).

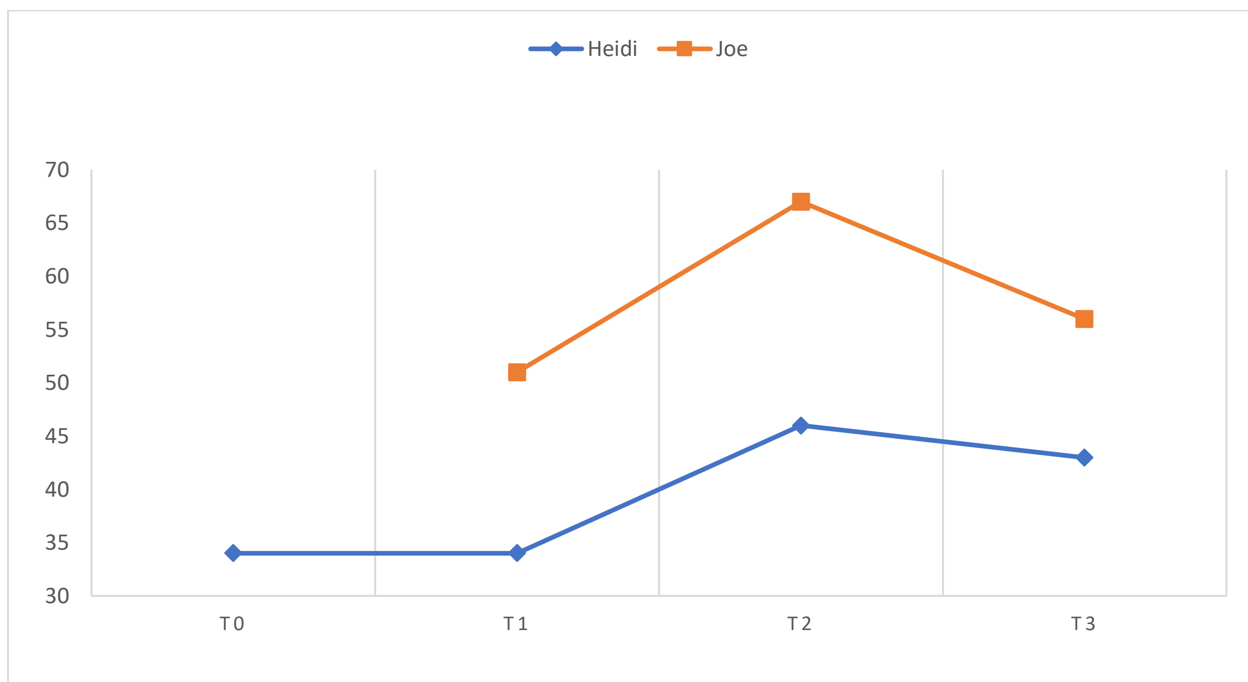


Figure 7 WEMWBS score progress of Heidi and Joe

The peer trainers

Esme

Esme has had problems with her mental health since her early teens, and these have meant that her life has not turned out as she would have liked it to. Being a peer trainer means that at last she feels that she is able to do something positive by using her experiences in ways that hopefully help other people. In 1987 her OCD became intolerable and brain surgery was given as an option which was carried out but it never helped.

Esme heard about Recovery in Mind through the CMHT, where she had been a patient since moving to the area a few years before and where she had already come to know Fiona. Esme has found Recovery in Mind has helped her in ways that other mental health services have not because its courses have taught her new practical and emotional skills for living and managing her own life. As a student, she also valued the atmosphere in the classrooms, the support, the lack of pressure, the friendliness, and the way that students could pick and choose whichever courses they thought would work for them. She has always been good at DIY, and likes to think of Recovery in Mind as a DIY way of helping yourself get on top of your poor mental health.

After nearly a year, Fiona approached Esme and invited her to become a peer trainer. Esme was absolutely elated to have been asked, and felt hugely moved by the thought that others might find her lived experience of value to them. She was delighted to agree.

Having previously worked as a learning support assistant at a local college, Esme already understood something of the principles of supporting students in class. From the outset, though, she recognised the peer trainer role as distinct because of the way it enabled her to let students know that she is on the same wavelength as them. Whenever she shared from personal experience, Esme quickly noticed how carefully students would listen to her, and how this enabled her to say things that the OTs could not. She believes that the kindest and most effective way that peer trainers can support people with mental health problems is to help them not to use their anxiety/depression as an excuse for what they cannot do and instead try to show them what they can do to help themselves.

The Covid-19 pandemic has proved a particularly challenging time for Esme for several reasons. Firstly, she lives alone in a retirement flat, and was therefore able to have contact with family and friends only through Zoom. Secondly, her OCD has long involved checking, and she was working especially determinedly to resist this, because she knew that she would not be able to see the doctor or dentist or to invite repair people to her flat. Nevertheless, Esme has coped extremely well, in part due to the skills learned at Recovery in Mind, and in part due to her commitment to supporting other students. She has participated in a number of the outdoor sessions, and has invested an exceptional amount of time and dedication in helping to run each of the online courses.

As Recovery in Mind returns to face-to-face activities, Esme is particularly excited about the allotment sessions, and about the classes planned to run from its polytunnel. She believes that austerity and cuts will continue to reduce the mental health care available to the local people, and is keen that Recovery in Mind should therefore continue to support people to discover what they can do to help themselves.

Lynn

Until she'd heard Angela describing Recovery in Mind on local radio one day in 2015, Lynn had never heard anyone speaking so openly about having had psychosis. None of the people around her had ever really talked about that sort of thing, so Lynn had never realised there would be anyone out there who would understand what she'd been through. It was that day that Lynn made it her mission to find Recovery in Mind.

Having made contact with Angela, and having signed up for Welcome to Recovery, Lynn suddenly felt nervous, as she wasn't sure she was in the right place. The OTs were great at making her feel welcome, though, and being around people who understood opened up

something very new for her. The best thing about Recovery in Mind at the beginning for Lynn was knowing that everyone in that room was suffering from something to do with mental health. The other thing which helped was that Recovery in Mind was just like a normal building, so that nobody walking past would think, “Oh, you’re going there because you’ve got mental health problems,” which is something a lot of students say has been good.

As a former receptionist, hairdresser and makeup artist, Lynn has always been good at talking to people, and she is a very creative person, too. Recovery in Mind’s photography group was the one she particularly enjoyed, and she also always loved watching other students discover their own talents in painting and pottery and gardening. It was good to keep trying new things. Through these new skills, Lynn has found the tools to be able to keep herself well, which is the most important thing in the world to her.

Angela invited Lynn to move from being a student to a peer trainer in 2016 because she could see how good she is with people, and how good at supporting others. At the beginning, Lynn worked with Angela to give talks about Recovery in Mind, and they both enjoyed this, even though Lynn had felt nervous beforehand about whether anyone would want to listen to her. Lynn then started taking the peer trainer role within the courses, not as someone who knows everything or had got there yet, but as a work in progress.

For Lynn, the most important parts of being a peer trainer are having a sense of humour and knowing not to take it personally when others are having a bad day. If you are doing the role well, you get so much from it for yourself, too.

Lynn has found Covid to difficult time, though she recognises that it has been hugely more difficult for those who live alone. She believes that Recovery in Mind has responded particularly well through the outdoor courses and activities it ran, and through its work with Sport in Mind and the allotment. She has been able to draw upon what she has learned as a student and a peer trainer by keeping active and staying creative, and she has been painting a lot, in particular.

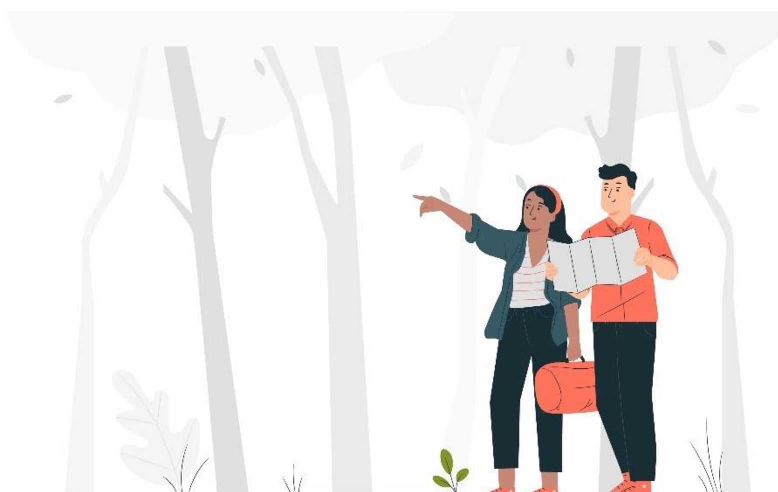
In the future, and as we all learn to live with the ongoing effects of Covid, Lynn hopes that Recovery in Mind will continue to raise awareness of mental health, will continue with its outdoor work, and will continue to reach out to those who live alone.

Chapter 8 Pausing and Looking at the Map: Where Have We Been and What Have We Learned?

An overview of the research findings

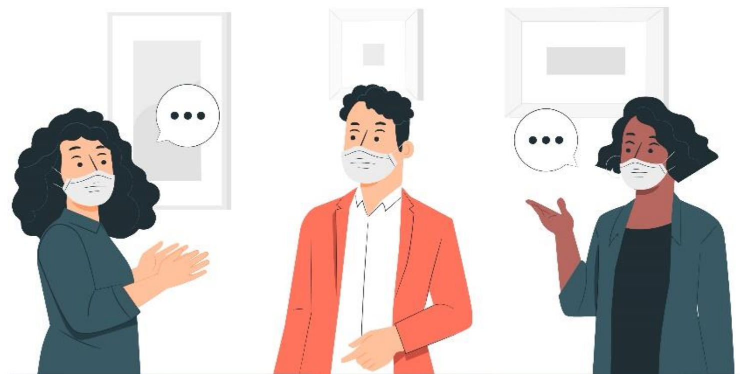
This research found that students join RiM with very low levels of wellbeing. RiM participation helps students to improve their wellbeing and mental health, though rarely to the extent of matching the general population. RiM may help women more than men, though this is difficult to establish because few men participated in the research. Most students are White middle-aged women who join RiM on the advice of their GPs or CMHTs. A large number of students leave RiM between the initial Stage 1 Bitesize session and the five-week Welcome to Recovery course, though it is unclear why, and unclear whether Covid has affected this.

Students described the most valuable skills as mindfulness, being aware of one's surroundings, creativity, and being with others. Students used the skills taught and learned in the RiM classes, and the toolbox metaphor around which these were structured, to develop increasingly personalised strategies to improve their longer-term wellbeing and resilience. Even for those students who had received mental health support in the past, much of what RiM taught was new, either in the course content, or in the manner of its delivery. Being part of RiM, and being among others who understood, helped students to practise the skills and strategies they were developing. Students gave and received a huge amount of support to and from one another. They spoke fondly of the staff and peer trainers, and especially of Angela, and drew inspiration from the teamwork they observed from the RiM leadership.



Both of the peer trainers interviewed had found being an RiM student extremely helpful to them, and both are now passionate advocates of RiM and of the concepts of recovery and co-production. They enjoy supporting other students, and find that the peer trainer role goes beyond their lived experience to enable them to use their other skills.

The Covid-19 pandemic has affected the entire lives of everyone at RiM, and many students and peer trainers have found the past year immensely difficult. Nevertheless, students have welcomed the way that RiM has adapted to offering online and socially distanced outdoor activities. In particular, students have valued the way that RiM has helped them to feel connected to others and to their local community.



How does Recovery in Mind help students to improve their mental health?

As educational establishments rather than mental health providers, Recovery Colleges aim to teach, and aim to empower students by what they teach (20). This research found that students benefitted from Recovery in Mind both as a result of the "toolkit" skills which they learned from courses, and because of their less tangible experience of simply being part of RiM.

For some students, the content that RiM courses and workshops teach was new to them; the idea that they could take ownership of their own wellbeing or even discuss their mental health concerns with others had been an exciting revelation. For other students, however, much of what RiM teaches was similar to what they'd already been told about by mental health professionals, therapists, or the media; what was new to them was the way that RiM provided the structure and the space to enable them to discuss what they were learning, and to think with others about how they might put this learning into practice. RiM not only teaches skills and strategies which students can use to improve their own wellbeing, but it promotes the concept and possibility of recovery and facilitates an atmosphere and a culture within which students can empower and learn from one another. All students derived mental health benefit from the experience of belonging and affirmation that RiM thereby provided. Being among people on similar journeys, they found, was equally as

empowering as the content of what the RiM courses directly taught. The "hidden curriculum" (21) of belongingness proved as effective as the curriculum of the recovery skills taught.

From its inception, the Recovery College movement has endorsed Freire's (53) critique of the so-called "banking model", within which the authoritative and respectable teacher deposits knowledge within the minds of grateful, passive, and ignorant students (21, 54). Often, this "banking model" remains the predominant educational paradigm within the "psychoeducation" delivered within mental health services (54). This psychoeducational approach is problematic for recovery-based learning because it reinforces the traditional epistemic and power imbalance between professional and patient, and because it perpetuates stigmatising archetypes of mental health patients as undereducated or unintelligent. As a result, Repper and Perkins insist that Recovery Colleges should follow more emancipatory, social, and active models of learning (21, 53), facilitating spaces where students learn from doing as well as from listening, learn from one another as well as from staff, and use their newly acquired learning as a means to empower themselves.
Some Recovery Colleges take an explicitly radical or "rights-based recovery" approach to challenging the psychoeducational model of mental health learning, engaging in activism against mental health stigma and neoliberal austerity, and offering courses in anti-psychiatry and emancipatory political consciousness (55). For RiM, as for many other Recovery Colleges, the empowerment which social and active co-learning provides remains more implicit, imparted instead through what educational theory terms the "hidden curriculum" (21, 56). It has long been known that all educational establishments deliver a hidden curriculum of the values, expectations, and aspirations that its organisational culture imparts to students, and it is becoming increasingly recognised that health-related educational establishments often deliver the most attitudinally directive forms of hidden curriculum (57). Within RiM, the hidden curriculum is delivered through the empowering space which staff and peer trainers facilitate to enable students to talk to one another, learn from one another, support one another, socialise, and form a sense of collective identity and belonging.

Within this research, students described the sense of belonging they gained from RiM's hidden curriculum as of immense benefit to their mental health. Being together with others undertaking similar journeys through mental ill-health, isolation, and uncertainty, and realising collectively that the concept and possibility of recovery could offer self-determination and hope, helped students to feel more comfortable with being themselves and being part of their communities. Within more phenomenological approaches to research into the lived experience of health and illness, the concepts of being and belonging (58) are regarded as crucial to wellbeing (59, 60) and to the emancipation and

empowerment derived within institutional cultures. Within RiM, and within the Recovery College movement more broadly, the mental health value of the hidden curriculum's promotion of belonging might be beneficial to explore further.

Therefore, RiM benefits the mental health of its students in two ways: firstly, through its curriculum of toolkit skills; and secondly, through the sense of belonging that its hidden curriculum of social learning and empowerment promotes. This research found that the RiM leadership was aware of both, though found it easier to describe the former. The hidden curriculum and the implicit staff team process and dynamics are less frequently articulated even when intentionally explored. While the whole RiM team acknowledges that the implicit hidden curriculum, and the structure and process through which to deliver this, were probably much more important than the explicit content RiM teaches, articulating the mechanism of delivery and its mental health values in words nevertheless proved difficult. Within educational research, theories are divided as to whether or not institutions should explicitly promote or acknowledge their hidden curriculums to students (57). For Recovery Colleges like RiM, which rely so heavily upon their hidden curriculum, this question could form the basis of valuable future research.

How do Angela and the peer trainers make Recovery in Mind different from other Recovery Colleges?

Central to the Recovery College model is the role of the peer trainers, former students who make use of their lived experience and recovery to co-deliver courses and to provide support to students (20). In this research, RiM students spoke highly of how Angela and the peer trainers drew upon their knowledge and experience. Over the past five years, Angela has intentionally shared increasingly fewer details of her personal recovery journey with RiM groups, and has provided progressively less one-to-one support to individual students, delegating this role to newer peer trainers in order to model the Recovery College emphasis on moving forward. Students spoke highly of Angela's delegation and moving forward, which meant that the peer trainers and staff encouraged an atmosphere in which students could learn from, support, and empower one another.

What particularly appears to distinguish RiM from most other Recovery Colleges is the way that Angela, as RiM founder and manager, is a person with lived experience of mental ill-health and not a mental health professional (employed within a statutory service structure).

Notwithstanding the Recovery College model's ethos of co-production and of valuing lived experience as equal to professional experience, most Recovery Colleges are led and managed by mental health professionals, and many Recovery Colleges do not treat their

peer workers with equity. Over the past 20 years, mental health services have been known for the institutionalised and systemically poor working conditions they offer to their experts by experience, lived experience practitioners, and peer support workers (61). As Perkins and Repper themselves acknowledge (27), the Recovery College model has done less than expected to ameliorate this. Despite their commitment to lived experience and democratically meaningful co-production, many Recovery Colleges employ their peer trainers on lower pay grades and less secure contracts than the professional colleagues with whom they share equal responsibility (27).

At RiM, the salaries of Cath and Fiona are funded by the local Trust in accordance with usual NHS pay scales, and the salaries of Angela and the peer trainers are financed from RiM core funds which Angela single-handedly raised through numerous grant applications, resulting in short- to medium-term small funds. Given that RiM lacks the income to pay Angela and the peer trainers a salary commensurate with professional rates, this means that RiM, like many other Recovery Colleges, has staff paid more than peer workers. Angela has sought to address this in two ways. Firstly, she ensures that peer trainers are paid in excess of the local living wage, and has paid peer trainers for work they would have done if not for the disruption of Covid-19. Secondly, and because she identifies as a peer herself regardless of bearing multiple roles and senior responsibilities including CEO, fund-raiser, and manager, Angela ensures she takes a salary on par with the hourly rate of other peer trainers. However, this leaves Angela as well as the peer trainers on an extremely low income and essentially a zero-hour contract.

This is additionally problematic because another distinctive feature of RiM is the way in which the roles of Angela and the other peer trainers extend beyond their lived experiences of mental ill-health. Angela manages RiM by drawing not only upon her lived experience of mental ill-health but upon her longstanding professional experience and expertise as a voluntary sector manager. Similarly, the RiM peer trainers Esme and Lynn are effective in supporting students because they draw upon both their lived experiences and their interpersonal strengths transferred from their respective careers in educational support and reception work. However, Angela earns from RiM significantly less than she might as a manager elsewhere in the voluntary sector, and Esme and Lynn earn significantly less than in their previous careers.

Historically, models of mental health user involvement and peer support have been predicated upon the conventional dichotomy between lived experience and professional experience that has been used both to safeguard professional boundaries and to maintain the “othering” of mental health patients (62). Recovery Colleges have rarely challenged this dichotomy (63).

Therefore, Angela and the RiM peer trainers are challenging the limitations and constraints which many Recovery Colleges place upon the peer role. RiM is not unique in seeking to extend the peer role, and Angela has drawn upon the work of Waldo Roeg from the Central and North West London NHS Trust Recovery and Wellbeing College (64). Several of the UK's other independent Recovery Colleges, such as Tyneside's ReCoCo Collective (55), are also managed by peers. Nevertheless, it remains a paradox that, while co-production with active involvement from experts through experience is heralded as fundamental in Recovery Colleges, their recognition in the formal organisational structure and its career pathways and pay systems is far from assimilated. While RiM has proved its success, its long-term sustainability is still, somehow, reliant on this very matter of social equity.

What might RiM learn from this research

Working with students with very low levels of wellbeing

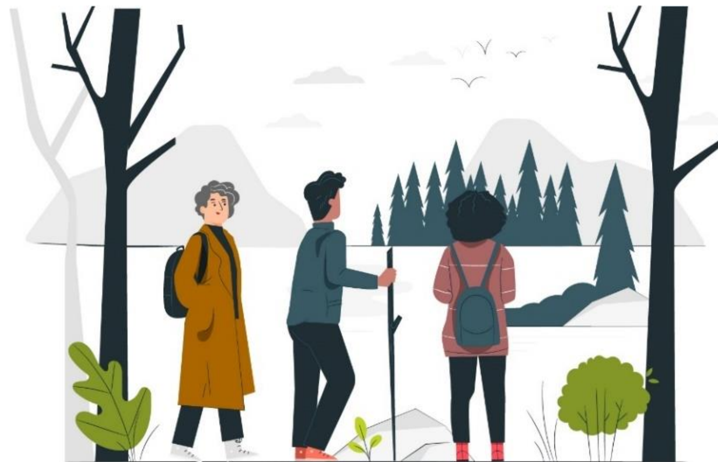
Both the quantitative and the qualitative components of this research have confirmed what the RiM leadership has always known anecdotally, which is that people often join RiM after discharge from the CMHT with significant unresolved mental health needs. What this research also found, however, was that the majority of students have significantly – and surprisingly – poor levels of wellbeing. Given that WEMWBS is a tool designed to measure mental health rather than mental ill-health or illness, it cannot necessarily be inferred that these low levels of wellbeing indicate specific mental health needs. Nevertheless, RiM may benefit from understanding how subjectively unhappy and dissatisfied with life those undertaking the Stage 1 Bitesize may be.

Both the quantitative and the qualitative components of this research concur that RiM is effective in improving wellbeing, particularly during the Stage 2 WTR course. For many students, however, these improvements are only partially still present three months later. Given the disruption caused by Covid-19, it may be that this apparent decline could otherwise have been mitigated by students starting Stage 3 courses, voluntary work, or other community activities immediately after finishing Stage 2. Given, however, the likelihood that Covid-19 may cause ongoing disruptions to RiM schedules, it might be helpful for the RiM leadership to consider how the WTR course could more effectively encourage students to maintain their wellbeing independently.

Learning from attrition

RiM has never sought to keep track of students who do not progress between the stages of its courses, nor of students who leave a course between sessions. In intentionally not doing

so, RiM remains faithful to the Recovery College ethos of it being an opt-in organisation which seeks only to engage those who wish to participate. This research showed, however, that significant numbers of students do leave. From the data available, it is not possible to establish why, or to what extent this might be due to Covid-19 or the move to online working, or due to other factors. Many educational establishments track their patterns of attrition with the aim of understanding their strengths and improving their provision. It may be that students disengage from RiM after the Stage 1 Bitesize or Stage 2 Welcome to Recovery because these courses have already provided them with the help they need, for example by encouraging them towards volunteering. However, it may be that students do not progress through the stages or leave courses midway because they find them unsuitable in ways that the RiM leadership is unaware of. The tendency of students to disengage rather than to explain their difficulties, and the receptiveness of RiM to challenging feedback, has been illustrated through the interviews; as soon as the RiM team heard from one student that another had found the concept of a "Walk and Talk" too demanding, they immediately renamed the activity "Ponder and Wander", with great success. It may be, therefore, that RiM could perhaps benefit from tracking the student journeys not only of those who remain, but of those who leave.



Promoting diversity and positive mental wellbeing

The demographics of the participants within this research – mainly White, predominantly female, and mostly of middle age and older – reflected the demographics of the RiM student body. As Angela and the RiM peer trainers and staff have long acknowledged, RiM tends to be less effective in engaging with men, BAME people, and younger adults. In recognition of this and RiM's commitment to the equality, diversity, and inclusion principles, RiM has recently secured, from the Gerald Palmer Eling Trust, 50% of the funding needed to employ a young person's worker.

In seeking further to encourage diversity, RiM might also wish to consider ways of proactively seeking participation from a greater range of sources. This research has shown

that most came to RiM via either their GPs or their CMHT. Whereas it is encouraging that GPs and CMHT staff are providing this signposting, previous surveys have shown that men and members of some BAME groups are less likely than White women to approach their GPs for mental health concerns (65). Furthermore, previous research has suggested that CMHTs may be less likely to refer Black people to community-based sources of mental health support (66). Especially as RiM seeks, in the wake of Covid-19, not only to address mental ill-health but to promote positive mental wellbeing, RiM might look for students from a range of places beyond health and care settings: for example, further education colleges, youth clubs, faith communities, and other community projects. Students have also suggested that RiM engage with local employers, both as a means of addressing workplace mental health and as means of challenging mental health stigma.

Part of RiM's vision for encouraging diversity is its aim not only to address mental ill-health but to promote positive mental wellbeing. This is reflected most visibly in their Stage 3 course Five Ways to Wellbeing, which draws upon work from the New Economics Foundation (67) that is often used in public mental health initiatives, but is also implicit within the RiM hidden curriculum. Students who were interviewed endorsed this view that much of what RiM teaches could be beneficial to everyone, particularly during the stress of the Covid-19 pandemic.

The strengths and limitations of this research

As a mixed-methods study, this research has been strengthened by gathering and triangulating its data in a range of ways, combining the rigour of both quantitative and qualitative approaches. Like Recovery Colleges themselves, this research has been co-produced, designed, and undertaken in collaboration between RiM students, peer trainers and staff, and independent researchers. Both the choice of WEMWBS as a statistical tool and the interview questions for the qualitative protocol were developed and piloted collaboratively, ensuring that that the research was engaging, comprehensible, and meaningful to students. Although the Covid-19 pandemic prevented researchers from visiting RiM, this co-productive approach nevertheless enabled researchers to experience and to appreciate something of the epistemology and methods of Recovery College practice. As a result of this shared understanding, WEMWBS was agreed as a statistical tool which measured positive mental wellbeing in close accordance with the RiM ethos, while enabling comparison with the general population.

Like all research undertaken during 2020 and 2021, however, the Covid-19 pandemic posed several unforeseen obstacles. Fewer students participated in the WEMWBS data collection than initially hoped. Given the relative homogeneity of students in terms of gender, age

range, and ethnicity – most students were White women in their 40s and 50s – this smaller sample size made it difficult to undertake subgroup analysis. In particular, it was difficult to quantify outcomes for men and BAME students, and difficult to analyse the differences between students and peer trainers.

The qualitative interviews, the dates for which had originally been planned for the first week of the March 2020 lockdown, proved difficult; as it was a time of such uncertainty and stress for the whole world, students and peer trainers alike found it difficult to reflect upon their experiences of wellbeing, and none were yet familiar with remote ways of working. In recognition of this, the team postponed interviews until March 2021. This proved valuable because it enabled students to become more comfortable with online interviews and to reflect upon the impact of Covid-19 upon RiM and themselves. However, the disadvantage of this postponement was that a number of the students and peer trainers selected were no longer available for interviews.

The future of Recovery in Mind

Like every other educational institution and mental health organisation, RiM is currently learning how to respond and adapt to a post-Covid world, and to the emerging mental health needs and ways of discussing mental health that this post-Covid world will bring. All of the RiM leadership are thoughtfully engaged in considering the future. The many and varied partnerships and collaborations which RiM had established prior to Covid with local statutory and voluntary organisations across West Berkshire is facilitating a number of new directions. The semi-rural nature of West Berkshire also places RiM in a strong position, as there are many opportunities for outdoor activities. This research found that students are open to new experiences. Students would like RiM to do more to challenge mental health stigma, especially as it affects people of working age.

Previous research has demonstrated that the Covid-19 pandemic has left increasing numbers of people struggling with their mental health (68), and the escalating burden on NHS mental health services means that the criteria required for NHS care are likely to narrow. The pandemic has led a high proportion of people in the UK with pre-existing mental health concerns to require more support than that needed prior to Covid-19 (69, 70). Given the escalating burden on NHS mental health services, successful local voluntary sector providers such as RiM will have a more crucial role to play than ever before. For voluntary sector organisations to operate in ways that are consistently responsive to local need, stable funding is essential. RiM's greatest need, at present, then, is for secure and sustainable funding to enable it to respond to the still unfolding long-term effects of the Covid-19 pandemic.

Some Recovery Colleges have attained financial sustainability through partnership with statutory services, typically mental health trusts and Local Authority social care services. At present, the local NHS Trust funds the salaries of Fiona and Cath and makes a small contribution towards the office costs. It may be that RiM would benefit from higher levels of NHS funding. However, the organisational structure of many statutory services is configurated such that any such funding of a Recovery College may require the Recovery College to be subsumed into the service's mechanisms of leadership and governance. For RiM to become part of a larger statutory service might leave Angela and the RiM leadership accountable not only to Recovery College principles and to students, but answerable to a higher tier of management and to organisational policy. By surrendering its independence, RiM may also lose something of the peer leadership and co-production which are its greatest strengths. For RiM, such partnership would have both advantages and disadvantages.

Several of the RiM students interviewed for this research have suggested that RiM should become more involved in challenging mental health stigma at local community level. One student has suggested that RiM should consider partnering with local businesses to offer support to employees. With workplace mental health and mental health discrimination becoming increasingly prominent concerns for the private sector, local employers might find that collaborating with and funding RiM is a useful way to evidence their social responsibility and community involvement.

The ongoing effects of the Covid-19 pandemic have meant that the grant-making trusts which have hitherto funded RiM are currently, like the whole UK voluntary sector, facing unprecedented demand. The whole RiM team hopes that the successes of and value provided by RiM demonstrated in this research study will encourage these grant-making trusts to continue to support RiM, and possibly others to join with their support too. As Angela concludes:

> The loneliness, isolation and self-stigma caused by my own mental illness has been negated by the sense of togetherness, compassion and care that is possible when Recovery is shared with the Recovery in Mind tribe. My next wish would be to have more 'vehicles' going in a positive direction for others to join the journey of Recovery. Discovery, self-understanding, shared values and the tools you need to drive your own car (mind) and how to look after it in the long term (wellbeing).

References

1. Oliver M. The Journey. USA: Atlantic Monthly Press; 1986.
2. RIM. Newsletter No 15 16/07/2020: Recovery in Mind; 2020 [Available from: https://j6d3c8k7.stackpathcdn.com/wp-content/uploads/2020/07/PUBLIC-Newsletter-No15-16th-July.pdf].
3. WHO. WHO QualityRights Tool Kit: Assessing and improving quality and human rights in mental health and social care facilities. Geneva: WHO; 2012.
4. Davidson L. Recovery, self management and the expert patient–Changing the culture of mental health from a UK perspective. Journal of mental health. 2005;14(1):25-35.
5. Woods A, Hart A, Spandler H. The recovery narrative: politics and possibilities of a genre. Culture, Medicine, and Psychiatry. 2019:1-27.
6. Deegan G. Discovering recovery. Psychiatric Rehabilitation Journal. 2003;26(4):368.
7. McCranie A. Recovery in mental illness: The roots, meanings, and implementations of a 'new'services movement. The SAGE handbook of mental health and illness. 2010:471-89.
8. Bonney S, Stickley T. Recovery and mental health: a review of the British literature. Journal of psychiatric and mental health nursing. 2008;15(2):140-53.
9. Bertram M, McDonald S. From surviving to thriving: how does that happen. The Journal of Mental Health Training, Education and Practice. 2015.
10. Braslow JT. The manufacture of recovery. Annual review of clinical psychology. 2013;9:781-809.
11. Campbell C. Social capital, social movements and global public health: Fighting for health-enabling contexts in marginalised settings. Social Science & Medicine. 2020;257:112153.
12. Ellison ML, Belanger LK, Niles BL, Evans LC, Bauer MS. Explication and definition of mental health recovery: A systematic review. Administration and Policy in Mental Health and Mental Health Services Research. 2018;45(1):91-102.
13. Winsper C, Crawford-Docherty A, Weich S, Fenton S-J, Singh SP. How do recovery-oriented interventions contribute to personal mental health recovery? A systematic review and logic model. Clinical psychology review. 2020;76:101815.
14. McCabe R, Whittington R, Cramond L, Perkins E. Contested understandings of recovery in mental health. Journal of Mental Health. 2018;27(5):475-81.
15. Quaye H, Rennoldson M. "Technically well, but not really": carers' constructions of recovery from psychosis. Journal of Mental Health. 2018.
16. Slade M, Amering M, Farkas M, Hamilton B, O'Hagan M, Panther G, et al. Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. World Psychiatry. 2014;13(1):12-20.
17. Coffey M, Hannigan B, Meudell A, Jones M, Hunt J, Fitzsimmons D. Quality of life, recovery and decision-making: a mixed methods study of mental health recovery in social care. Social psychiatry and psychiatric epidemiology. 2019;54(6):715-23.
18. Law H, Gee B, Dehmahdi N, Carney R, Jackson C, Wheeler R, et al. What does recovery mean to young people with mental health difficulties?–"It's not this magical unspoken thing, it's just recovery". Journal of Mental Health. 2020;29(4):464-72.
19. ImROC. ImROC: Implementing Recovery through Organisational Change 2021 [Available from: https://imroc.org/.
20. Perkins RR, Julie; Rinaldi, Miles; Brown, Helen. Recovery Colleges. UK: Mental Health Network NHS Confederation; 2012.
21. McGregor J, Repper J, Brown H. "The college is so different from anything I have done". A study of the characteristics of Nottingham Recovery College. The Journal of Mental Health Training, Education and Practice. 2014.

22. Thériault J, Lord M-M, Briand C, Piat M, Meddings S. Recovery Colleges After a Decade of Research: A Literature Review. Psychiatric Services. 2020;71(9):928-40.
23. Whitley R, Shepherd G, Slade M. Recovery colleges as a mental health innovation. World Psychiatry. 2019;18(2):141.
24. Crowther A, Taylor A, Toney R, Meddings S, Whale T, Jennings H, et al. The impact of Recovery Colleges on mental health staff, services and society. Epidemiology and psychiatric sciences. 2019;28(5):481.
25. Newman-Taylor K, Stone N, Valentine P, Hooks Z, Sault K. The Recovery College: A unique service approach and qualitative evaluation. Psychiatric rehabilitation journal. 2016;39(2):187.
26. Zabel E, Donegan G, Lawrence K, French P. Exploring the impact of the recovery academy: a qualitative study of Recovery College experiences. The Journal of Mental Health Training, Education and Practice. 2016.
27. Perkins R, Repper J. When is a "recovery college" not a "recovery college". Mental Health and Social Inclusion. 2017;21(2):65-72.
28. Cameron J, Hart A, Brooker S, Neale P, Reardon M. Collaboration in the design and delivery of a mental health recovery college course: experiences of students and tutors. Journal of Mental Health. 2018;27(4):374-81.
29. Wilson C, King M, Russell J. A mixed-methods evaluation of a Recovery College in South East Essex for people with mental health difficulties. Health & social care in the community. 2019;27(5):1353-62.
30. King T, Meddings S. Survey identifying commonality across international recovery colleges. Mental Health and Social Inclusion. 2019.
31. Bourne P, Meddings S, Whittington A. An evaluation of service use outcomes in a recovery college. Journal of Mental Health. 2018;27(4):359-66.
32. Stevens J, Butterfield C, Whittington A, Holttum S. Evaluation of arts based courses within a UK recovery college for people with mental health challenges. International journal of environmental research and public health. 2018;15(6):1170.
33. Newman-Taylor K, Maguire T, Bowen A. Why are we not measuring what matters in mental health in the UK? The case for routine use of recovery outcome measures. Perspectives in public health. 2019;139(4):181-3.
34. RIM. Newsletter No 10 11/06/2020: Recovery in Mind; 2020 [Available from: https://j6d3c8k7.stackpathcdn.com/wp-content/uploads/2020/06/PUBLIC-Newsletter-No10-11th-June.pdf.
35. RIM. Recovery in Mind newsletters: Recovery in Mind; 2020 [Available from: https://recoveryinmind.org/news/newsletters/.
36. RIM. Bitesize: Welcome to Recovery: Recovery in Mind; 2020 [Available from: https://recoveryinmind.org/free-courses/step-1/.
37. RIM. Nano Courses: Recovery in Mind; 2020 [Available from: https://recoveryinmind.org/category/nano-courses/.
38. RIM. Relaxation: Recovery in Mind; 2020 [Available from: https://recoveryinmind.org/category/recordings/.
39. Denzin NK, Lincoln YS. The Sage handbook of Qualitative Research. UK: Sage; 2011.
40. Butler I. Doing good research and doing it well: Ethical awareness and the production of social work research. Social work education. 2003;22(1):19-30.
41. Tennant R, Hiller L, Fishwick R, Platt S, Joseph S, Weich S, et al. The Warwick-Edinburgh mental well-being scale (WEMWBS): development and UK validation. Health and Quality of life Outcomes. 2007;5(1):1-13.
42. Llewellyn-Beardsley J, Rennick-Egglestone S, Bradstreet S, Davidson L, Franklin D, Hui A, et al. Not the story you want? Assessing the fit of a conceptual framework characterising mental health recovery narratives. Social psychiatry and psychiatric epidemiology. 2020;55(3):295-308.
43. Greene JC. Mixed methods in Social Inquiry. USA: John Wiley & Sons; 2007.

44. Maheswaran H, Weich S, Powell J, Stewart-Brown S. Evaluating the responsiveness of the Warwick Edinburgh Mental Well-Being Scale (WEMWBS): Group and individual level analysis. Health and Quality of Life Outcomes. 2012;10(1):1-8.
45. Shah N, Cader M, Andrews WP, Wijesekera D, Stewart-Brown SL. Responsiveness of the short Warwick Edinburgh mental well-being scale (SWEMWBS): evaluation a clinical sample. Health and quality of life outcomes. 2018;16(1):1-7.
46. NHS. NHS Digital Health Survey for England (HSE) Adult wellbeing - Tables (version 2) 2016 [July 24 2021]. Available from: https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/health-survey-for-england-2016
47. Stewart-Brown S, Janmohamed K. Warwick-Edinburgh mental well-being scale. User guide Version. 2008;1.
48. Spencer L, Ritchie J, O'Connor W. Analysis: practices, principles and processes. Qualitative research practice: A guide for social science students and researchers. 2003;199:218.
49. Beauchamp TL, Childress JF. Principles of biomedical ethics: Oxford University Press, USA; 2001.
50. Marino E, Rivera-Gonzalez J, Benadusi M, Dietrich A, Hamza M, Jerolleman A, et al. COVID-19 and All the Things That Kill Us: Research Ethics in the Time of Pandemic. Practicing Anthropology. 2020;42(4):36-40.
51. Johnson S, Dalton-Locke C, San Juan NV, Foye U, Oram S, Papamichail A, et al. Impact on mental health care and on mental health service users of the COVID-19 pandemic: a mixed methods survey of UK mental health care staff. Social psychiatry and psychiatric epidemiology. 2021;56(1):25-37.
52. Stewart-Brown S, Samaraweera PC, Taggart F, Kandala N-B, Stranges S. Socioeconomic gradients and mental health: implications for public health. The British Journal of Psychiatry. 2015;206(6):461-5.
53. Freire P. Pedagogy of the Oppressed. USA: Routledge; 1968.
54. Oh H. The pedagogy of recovery colleges: clarifying theory. Mental Health Review Journal. 2013.
55. ReCoCo. Recovery College Collective Newcastle 2021 [July 1, 2021]. Available from: https://www.recoverycoco.com/.
56. Vygotsky L. 1978. Mind in society. Cambridge, MA: Harvard University Press; 1930.
57. Neve H, Collett T. Empowering students with the hidden curriculum. The clinical teacher. 2018;15(6):494-9.
58. Heidegger M. Being and time: A translation of Sein und Zeit (1996). USA: SUNY press; 1927.
59. Carel H. Illness: The cry of the flesh: Routledge; 2018.
60. Carel H. Ill, but well: A phenomenology of well-being in chronic illness. Disability and the good human life. 2014:243-70.
61. Byrne L. A grounded theory study of lived experience mental health practitioners within the wider workforce: Central Queensland University, Division og Higher Education; 2013.
62. Roennfeldt H, Byrne L. How much 'lived experience'is enough? Understanding mental health lived experience work from a management perspective. Australian Health Review. 2020;44(6):898-903.
63. RITB. Stepford Recovery College 2017 [July 1, 2021]. Available from: https://recoveryinthebin.org/stepford-recovery-college/.
64. CNWL. Central and North West London NHS Foundation Trust Recovery and Wellbeing College 2021 [July 1, 2021]. Available from: https://www.cnwl.nhs.uk/services/recovery-and-wellbeing-college.
65. Wendt D, Shafer K. Gender and attitudes about mental health help seeking: results from national data. Health & Social Work. 2016;41(1):e20-e8.

66. Truswell D, Bryant-Jefferies R. Responding to the Delivering Race Equality (DRE) agenda in mental health services: national recommendations informed by local experience. Ethnicity and Inequalities in Health and Social Care. 2010.
67. Farrier A, Dooris M, Froggett L. Five Ways to Wellbeing: holistic narratives of public health programme participants. Global health promotion. 2019;26(3):71-9.
68. Proto E, Quintana-Domeque C. COVID-19 and mental health deterioration by ethnicity and gender in the UK. PloS one. 2021;16(1):e0244419.
69. Burton A, McKinlay A, Aughterson H, Fancourt D. Impact of the Covid-19 pandemic on the mental health and wellbeing of adults with mental health conditions in the UK: A qualitative interview study. MedRxiv. 2021:2020.12. 01.20241067.
70. Gillard S, Dare C, Hardy J, Nyikavaranda P, Olive RR, Shah P, et al. Experiences of living with mental health problems during the COVID-19 pandemic in the UK: a coproduced, participatory qualitative interview study. Social psychiatry and psychiatric epidemiology. 2021:1-11.