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DOI:

[10.1111/jpm.12469](https://doi.org/10.1111/jpm.12469)

Document Version

Peer reviewed version

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Citation for published version (APA):

Oates, J. L., & Dalgarno, M. (2018). The meaning of co- production for clinicians: an exploratory case study of Practitioner Trainers in one Recovery College. *Journal of Psychiatric and Mental Health Nursing*, 25(5-6), 349-357. <https://doi.org/10.1111/jpm.12469>

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Article Type: Original Article

Title page

Title

The meaning of co- production for clinicians: an exploratory case study of Practitioner Trainers in one Recovery College

Short title

Recovery College Practitioner Trainers' experience

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Acknowledgements

none

Ethical statement

All the research met university and NHS ethical guidelines, including adherence to the legal requirements of the study country.

Title

The meaning of co-production for clinicians: an exploratory case study of Practitioner Trainers in one Recovery College

Accessible summary

What is known on the subject

- Analysis of co-production in mental health and specifically Recovery Colleges has not previously considered the impact on clinicians and their clinical practice.
- Co-production as a concept is open to multiple interpretations. Core components of co-produced work are: a focus on assets, mutuality, peer support and the use of a facilitative approach.

This article has been accepted for publication and undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the Version of Record. Please cite this article as doi: 10.1111/jpm.12469

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What this paper adds to existing knowledge

- Senior clinicians who have chosen to become Practitioner Trainers describe the experience of collaboration with service users in an educational rather than clinical context.
- Working together in this educational environment led to some shifts in their perceptions of professional power and authority, in some cases leading to personal disclosures about their mental health.
- This study suggests the mechanisms by which co-production may transform professional practice: being in an educational rather than clinical context, the experience of being supported, the challenge of negotiating multiple roles (including that of being a colleague to someone with mental health needs), and experiencing a gradual shift of role emphasis as co-trainer relationships develop.
- The practical challenge of holding a simultaneous role as clinician for and co-trainer with Peer Trainers has been articulated, with the caveat that mental health support may be a feature of collegiate as well as clinical roles.

What are the implications for practice

- Being a Practitioner Trainer could be a professionally transformative experience.
- Ground rules for how to support colleagues' mental health needs should be established and refined during co-produced working.
- Negotiating personal disclosure and professional role identity must be explored further in both co-production research and practice .

Abstract

Introduction: Co-production between service users and clinicians is a desirable element of recovery-oriented practice in mental health but the effect of co-production on clinicians has not been explored thoroughly.

Aim: to explore the meaning of co-production for clinicians based on their experience of co-production in a Recovery College

Method: Thematic analysis of eight semi-structured interviews with clinicians who have co-produced and co-delivered workshops with a Recovery College Peer Trainer.

Results: The 'meaning of co-production' had four themes: definitions, power dynamics, negotiating roles and influence on practice. Clinicians' experience of co-production meant a reassessment of their expert role and power. They said that this altered their clinical practice, particularly the language they used and the personal information they shared.

Discussion: Role negotiation between Practitioner and Peer Trainers is an iterative process, whereby clinicians may revise their perspectives on personal disclosure, professional identity and collegiate support. The Peer and Practitioner Trainer relationship is characterised by reciprocity and mutuality, and there is some evidence that Practitioner involvement in a co-produced activity has the potential to transform service user and provider relationships beyond the Recovery College setting.

Implications for practice: Engaging in co-produced educational workshops can alter clinicians' perspectives on roles, power and clinical expertise. Findings from this case study must be tested against research on other Recovery Colleges.

Keywords

Recovery; co-production; roles; qualitative methods; therapeutic relationships

Relevance statement

This study is relevant to mental health nursing practice, recruitment and training because it describes Practitioner Trainer perspectives on recovery-oriented mental health practice. As Recovery Colleges expand and proliferate we must consider the impact on clinicians as well as service users. This will improve the training and support of future Practitioner Trainers and should also inform the expansion of co-production beyond the Recovery College setting into service development and delivery.

Main body

Introduction

This paper explores the meaning of co-production for clinicians who have co-produced and co-delivered workshops in one Recovery College. Recovery-oriented practice has been a feature of mental health service provision for several years, and is mandated in the most recent national mental health policy guidance for England (Department of Health, 2011). Recovery-oriented mental health services value 'lived experience' as a form of expertise and aim to promote hope, self-efficacy and self-management (Fray et al 2016). NHS mental health service providers were recommended to develop 'recovery education centres' called Recovery Colleges (Perkins et al 2012) as an indicator of organisation-level commitment to 'recovery', alongside the establishment of Peer Support roles and use of 'person centred' safety planning (Shepherd et al, 2010). While criteria for Recovery Colleges are available, there is no specified universal model for co-production across services (National Development Team for Inclusion, NDTi 2016). As a result there may be significant local variation in

the interpretation and enactment of Recovery College practice, although the fidelity criteria generated from the Nottingham Recovery College (McGregor et al, 2014) have been adopted widely (McCaig et al, 2014; Meddings et al, 2016). These require that Recovery Colleges focus on 'education' over treatment, have an open door to service users, carers, family members and staff as college students. Importantly, Recovery Colleges must foreground co-production and co-facilitation by people with lived experience of mental health problems.

Recovery Colleges differ from traditional academic archetypes in which the teacher is viewed as having intellectual authority. Theirs is an ethos of less restrictive education, with students taking an active role to teach each other via their shared experience and with the teacher/ trainer role being focused on group facilitation (Kelly et al 2016). Recovery Colleges host classroom-style led workshops that may focus on managing specific conditions, such as 'Psychosis' or experiences, such as 'Stress'. They may have a practical focus such as 'Understanding state benefits'. According to the Recovery College ethos, mental health practitioners work alongside service users to co-produce workshops (Perkins *et al*, 2012). Both service users and clinical staff take on co-trainer roles, aiming for commonality without a 'them and us' viewpoint (Slay & Stephens 2013).

'Co-production' has its roots in the civil rights and social action movements in the United States in the 1970s where co-production was used as a means of fostering equality between professionals and citizens. Co-produced projects shifted the way power was enacted and perceived, for example between young people at risk of offending or between members of disenfranchised groups and professionals figures,

such as low income families and community nurses (Realpe and Wallace, 2010; Boyle and Harris, 2009). The core values of co-production as first defined by Cahn (2001) are: focusing on assets, redefining approaches to work, reciprocity, and use of social networks (Boyle and Harris, 2009). These were further expanded by Boyle et al (2010) to comprise six elements: recognising people as assets, building on their existing capabilities, mutuality and reciprocity, peer support, blurring distinctions, and facilitating rather than delivering.

The complementarity between 'co-production' and 'recovery oriented' mental health practice is obvious (Clark, 2015). Co-production as an approach to mental health service delivery challenges an established hierarchy and power imbalance between service users and clinicians (Pinfold et al 2015; Fisher, 2016). Needham and Carr argue that co-production as a process has the potential to transform services through 'a relocation of power and control' (2009, p. 6). For them, true 'transformative' co-production is when citizens (in this context, service users) are involved in all of service commissioning, design and delivery. This differs from merely 'basic, descriptive' accounts of co-production whereby citizen involvement is an aspect of a service, for example service users following treatment plans, or 'intermediate' co-production, whereby there is an element of the citizen's 'voice' incorporated in a service, for example the use of a 'service user reference group'. Because service user involvement and direction is integral to the Recovery College ethos, it meets Needham and Carr's definition of 'transformative' co-production. The Recovery College environment is one in which mental health service users commission, design and deliver the service and practitioners are invited to collaborate, co-facilitate and attend. Whether power shifts experienced during co-production have lasting effects

on Practitioner Trainers' relationships outside the Recovery College setting is yet to be explored.

Co-production as a concept has been described as 'excessively elastic', (Clark, 2015, after Needham and Carr, 2009), with Clark arguing that any discussion of co-production in mental health must begin with a clarification of how the term is being used and in what context. Where the case for 'co-production' as potentially transformative for services and service users has been well made, there is a lack of research on the impact of co-production on mental health clinicians rather than service user participants. The recent co-production literature review (Slay & Stephens, 2013) and supporting guidance (Social Care Institute for Excellence (SCIE) 2013) describe the impact of co-production on service users and service provision, but not on clinicians. Slay and Stephens' (2013) literature review noted some key themes of co-production including improving social networks and social inclusion, addressing stigma, improving skills and preventing ill health. The Recovery College literature so far has centred on the service user experience with minimal discussion of the practitioner experience. One service delivery report included consultant psychiatrist trainer's views on co-production at a Recovery College, describing it as a positive change in the power differential and collaborative working (McGregor et al 2014). Similarly Spencer et al (2013) report that practitioners involved in co-production describe greater job satisfaction, effectiveness and ownership. Practitioners felt self-empowered, trusted and fulfilled to be able to make a difference in people's lives. Davies et al (2014) report on a co-produced workshop for practitioners who worked with people with personality disorder diagnoses. They briefly describe the effect of co-production on 'experts by occupation' as well as 'experts by experience' saying it

was 'invaluable' as a means of enhancing clinical skills and increasing understanding of the service user perspective. The main focus of Recovery College research should be on the effectiveness of attending or running workshops on people with lived experience but the benefits to clinicians must also be explored. The aim of this qualitative study was to explore the meaning of co-production for clinical staff who had been involved in designing and delivering co-produced workshops at one Recovery College.

Methods

This study is reported with reference to COREQ criteria for qualitative research (Tong et al, 2007). Data was collected through face to face interviews conducted by one researcher, under the academic supervision of the second researcher. Interviews were undertaken in June 2017. They were transcribed and analysed in July/Aug 2017. The number of interviews was determined by the number of voluntary participants available via one Recovery College, who responded to an email sent by the Recovery College manager, requesting research participants. No incentives were given to take part.

The interviews were semi structured, using a topic guide (Holloway and Wheeler, 2013). Interviews were up to an hour in length. Braun and Clarke's (2006) six phase thematic analysis method was used. The first author undertook coding and thematic analysis. Reliability and validity were assured through comparative coding with the second author. Thematic analysis was used as it is a flexible approach that can support the management of a complex amount of data. In phase one data were collected via interviews then transcribed. In phase two the data set was coded using NVivo software. Deductive

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codes were derived, based on the research question but inductive codes also arose, for example the participants' reflections on their own mental health. In phase three codes were mapped against themes suggested by the research question and objectives. In phase four themes were reviewed and revised. In phase five codes were allocated to subthemes. In phase six the thematic analysis was used to develop a narrative report and formulate an answer to the research question.

Ethics

The study protocol was approved by the NHS Health Research Authority and the relevant university ethics committee. The research protocol, interview topic guide, participant information and consent form were all reviewed by the Recovery College Peer Trainers, in the spirit of service user participation (INVOLVE 2014). The interview was piloted with one member of the Recovery College team.

There were unique ethical concerns to be addressed in this study, namely the risk of identifying both Practitioner and Peer Trainers in any published accounts, due to the limited number of people in those roles at the single research site. Practitioners and Peers tend to work in pairs with the same colleague repeatedly, therefore Practitioner comments about their Peer colleagues run the risk of revealing personal information about them and their experience of mental distress, which may cause direct or indirect harm. Presentations of findings from the study have been screened by the authors to ensure individual Practitioners and Peers are not identifiable. Reported demographic information about participants has been kept to a minimum for this reason.

A second ethical concern was the lead researcher's pre-existing relationship with participants. As a practitioner in the field he was known to them. Care was taken to ensure there was no duress to take part, with the lead researcher not approaching potential interviewees directly. Information sharing about the project was done via a third party and required potential participants to initiate contact with the researcher if they wanted to take part.

Research participants

Interviewees were 'Practitioner Trainers' from one Recovery College. Their ages ranged from 30-55. There were three male and five female participants. They were all employed in senior clinical roles within the provider organisation. They had between two and four years' experience as Practitioner Trainers with the Recovery College,

Findings

Texts were analysed in the inductive mode described by Braun and Clark (2007). This led to the identification and exploration of four sub themes relating to the question of 'What is the meaning of co-production for Recovery College Practitioner Trainers?' The overarching theme associated with the meaning of co-production was: notions of power and professional role. Four sub themes were: 'defining co-production', 'power dynamics in co-production', 'negotiating roles as the challenge of co-production', and 'influence on professional practice'. Presentation of the thematic findings has stayed close to the language and verbal responses of the research participants.

Defining co-production

Participants defined co-production as 'collaborative working' and 'partnership' It was described as being larger than just having consultation or service user involvement. Most participants described a joint effort, between themselves and their Peer Trainer but also between themselves and the workshop participants, to create a workshop that benefitted all involved in the experience. Participants contrasted co-production in the Recovery College with other experiences of service user involvement such as working with service user representatives, service user involvement groups and forums. They saw Recovery College co-production as more 'in depth', 'less academic' with a less 'top down' approach. They described an impact on themselves, whereby Recovery College co-production was a learning experience that had helped their own self- growth as well as developing their understanding of service users' needs. One participant said 'it gives what I do so much substance.'

Co-production in the Recovery College meant having a common and agreed goal for the piece of work, in this case a co-produced workshop. co-production meant acknowledging the strengths that each person brought to the work with the aim of devising a the best learning experience together. Co-production differed from other experiences of service user involvement as it focused more on the collaborative process and supported the learning and growth of both trainers. Definitions of co-production focused on process over outcome, based on evolving relationships with Peer Trainers, as described by one participant thus:

'I think it isn't a word, co-producing is something that means working together collaboratively to make sure both views, knowledge and skills of two partners are equally represented.'

Power dynamics in co-production

In the initial, planning phase of the workshop when participants were getting to know a new Peer- Trainer, they were conscious of their different roles and respective' expertise.'

When they began to co-deliver workshops the Practitioner Trainer and Peer Trainer would each introduce their roles to the students in order to 'set the scene', but participants described how over time this differentiation seemed to diminish. There was also a sense that the Peer Trainer could provide a viewpoint on both the topic and group management, allowing the Practitioner Trainer to focus on the clinical content of the training. When planning the workshop, most agreed in advance who would take the lead in which part of the training. Some found it easier to do the same parts each time as they were more confident within a certain area, whilst most stated they shared the responsibilities for the workshop completely with their co-trainer.

Taking part in co-produced work meant a shift in power dynamics between clinician and service user, in new roles as Practitioner Trainer and Peer Trainer:

'You have to let some power go because we've all got these layers of protection around us.'

In the Recovery College Practitioner and Peer Trainers tended to be paired up for a period of time, meaning that a rapport would develop. Whilst the Practitioner Trainer brought expert subject knowledge, they were not necessarily the more experienced teacher or facilitator. Initially during workshop planning and delivery, the co-trainers

with the most experience of training and facilitation tended to take the lead, rather than the one with a particularly form of mental health knowledge or experience. Where Practitioner Trainers may have assumed they would both take the lead and be offering support, this was not always the case. In some instances the Peer Trainer took the lead on structure and design of the workshops and in some instances Peer Trainers supported them when challenging moments occurred. They were seen as helping the Practitioner Trainer to stay focused, answer questions dynamically and be aware of areas that they themselves may have missed. Four participants described how the Peer Trainers 'rescued' them during difficult moments in the classroom.

Several participants valued having someone with lived experience to co-deliver with, who could share their own experience of mental health problems and treatment with the Recovery College students, something they could not do by themselves. They described how this 'resonated' with workshop attendees. One participant described that being with someone with lived experience brought authenticity to the training by providing:

'another expert in a room in an area that I don't know about, who brings a real authenticity and reliability to proceedings. They straddle both. They have clinical expertise and they have real lived experience that you don't necessarily always get for the, kind of, sheltered upbringing of university education.'

For some participants, this shifting in roles and power dynamics did lead to them disclosing their own mental health experience. They learned to model openness in the workshops. This too was described as 'authenticity':

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‘There is something about when you feel contained and supported, a sort of mutuality- sharing in something, where you feel more able to perhaps talk honestly about what’s going on with yourself and I think that’s helpful for the group and for the learning as a whole’.

Within this theme there was a focus on the ‘strengths’ of the Peer Trainer more than the Practitioner Trainer. It appeared that in this way of working, participants focused on the powerful input that having someone with lived experience had on the training rather than what they as Practitioner Trainers brought into the room.

Negotiating roles as the challenge of co-production

For some participants letting go of power was a challenge. One participant described relinquishing power as ‘frightening and exposing’. For three participants power dynamics were altered through a trial-and-error approach. They described how over time power dynamics changed when both parties answered questions, shared responsibilities, shared views openly and worked on an equal footing. One participant talked about the challenge of already knowing the co-trainer in the capacity of being their clinician which led them to have concerns about a conflict of interest. In one role they were supporting that individual as their clinician and another as colleagues. The challenges arose in clarifying and adhering to roles within each of these different relationships.

Some Practitioner Trainers felt a responsibility to be protective of the co-trainer. In their usual clinical role, the Practitioner Trainer had responsibilities over the health and welfare of the service users in their care. Some acknowledged that in co-

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production the role was different, as their co-trainer was not one of their service users, rather a colleague who was sharing of personal experiences. However, some participants described scenarios where the Peer Trainer had asked for assistance relating to their mental health, so the Practitioner Trainer supported this. A sub theme here was how difficult it could be to work with a Peer co-trainer who might be unwell or becoming unwell. This meant that the Practitioner Trainer had to negotiate their dual role. At the same time participants contextualised this, saying that it was not unique to a co-production situation because other colleagues, staff they supervised or even they themselves may become mentally unwell. They stated that they supported the Peer Trainer in the same way they would manage other situations with colleagues, often by being honest in their reactions and asking how they could help.

As Peer and Practitioner Trainer relationships developed the power dynamics appeared to alter. At first the participants felt some level of responsibility and protectiveness towards the Peer Trainer, reflecting notions of accountability and duty of care symptomatic of their usual professional relationships with service users. Most participants described a blurring of roles over time. Participants described instances where the Peer Trainer delivered clinical aspects or answered clinical questions in the workshops. As a result, the gap between Practitioner-led theory and Peer-led narrative-driven approaches was narrowed. Most participants felt that they could voice more of their own personal experiences as they observing their co-trainer disclosing and sharing. Initially they were reluctant to disclose but some participants found, as time went on, it was authentic and humanistic to safely disclose their own difficulties and recovery strategies.

Influence on professional practice

Participants said that what happened in the Recovery College setting had an influence on their clinical practice outside the classroom. They described how this experience had led them to re-evaluate other aspects of their work, to consider how they might bring in a co-production element to other training. Co-production in a Recovery College was seen as a useful starting point for a rethink of other training and practice development activities, because of the framework in which all materials were co-produced. For example, one participant described how she now worked with peer support workers:

‘I’ve started to work with all of those people this year in quite interesting and different kind of ways and some really exciting ways. One of them, for example, I have been updating the online training that’s available for staff and the subject area that I cover. What I’ve done in that training now is I’ve got a link worker as the face for that training, so introducing the training and giving the staff who log in the message about why they should be doing this from a service user point of view. A service user’s story, reaching out to the staff to say this is what the course is about, this training session you’re about to begin. ‘

Dialogues with Peer Trainers and Recovery College students had made them rethink their use of language. They had become more aware of the confusion that arose through the use of clinical jargon. Most participants described how this experience meant that they had adapted the way they communicated information to service users and families. At a strategic level, those Practitioner Trainers in more senior roles

were calling for their Trust to review how it used language to increase accessibility.

One participant said:

‘I think about how I now verbalise the information I want to give family members and patients in a clinical setting.’

Similarly, another said:

‘I thought I was articulating things in an inclusive way that everybody would understand and then to get that played like holding a mirror up and get that played back to me that actually people wouldn’t understand that and it was very technical.’

The Recovery College experience had an impact on how many of the participants worked collaboratively with the service users in their clinical area. The experience of observing Peer Trainers disclose and share personal narratives and recovery journeys provided a template for how to ask about someone’s story and how this could be used to work collaboratively on the service user’s recovery, to support a more person-centred practice. One participant said that it had supported flexibility in the way they worked as they felt able to show vulnerability and acknowledge their own limitations, allowing for a humanistic approach to their own practice.

A number of the participants held senior professional roles and were involved in strategic development for their organisation . They recognised that often service users were given an opportunity to provide service delivery and development input but not necessarily to make service changes. Participation in Recovery College training had

led to a re-evaluation of what service user involvement meant in the areas of professional practice over which they had influence, leading them to consider how they could make this less tokenistic and more transformative. There was a commitment to taking co-production beyond the Recovery College.

Discussion

This study offers a new insight into the meaning of co-production in mental health, as seen by professionals taking on Recovery College Practitioner Trainer roles. Participation in co-production is shown as an opportunity for a negotiation and renegotiation of professional and service user relationships within and beyond the Recovery College setting. The language used by study participants ('mutuality', 'equal sharing' and 'letting go of power') is directly attributable to the core values and elements of co-production set out by Cahn (2001) and Boyle and Harris (2010). Participants described their experiences in terms that are familiar within the co-production literature, but from a less familiar angle, that of the professional. They, as well as service users, seem to experience emancipation through being in a setting where expertise and mutual support may be fluid, evolving and multifaceted. Where at times they may still be called upon to 'support' or 'advise' their Peer Trainer colleague, this was differentiated from how they might do this in a clinical context. They may also be supported by, led or 'rescued' by their co-trainer. For some participants, the co-produced workshop became a space in which they talked about their own mental health, drawing on their 'expertise by experience' as well as 'expertise by occupation.' This notion of variation in practitioners' use of their own 'expertise by experience' was also noted by Oates et al (2017) in their interviews with nurses with personal experience of mental health problems. Disclosure in the Recovery College set-

ting was seen as 'appropriate' and a sign of 'strength', and not just the domain of the service user. It could enhance credibility and carried less risk than in their usual professional-service user encounters.

Needham and Carr (2009) argue that co-production at its most effective is 'transformative'. Transformation in relation to co-production means a redefinition of power where more power is held by the citizen because the citizen (here service user) plays a central role in all aspects. Working with service users in the Recovery College setting led to participants' redefinition of their working relationships with service users, over time with their co-trainers but also outside of the Recovery College context. In the initial stages of working together, Practitioner Trainers were more conscious of presupposed roles and responsibilities, but these were not static. Recovery College work may be the first time that the clinician had been supported by a service user rather than supporting them. Where clinicians take part in Recovery College delivery as Practitioner Trainers, according to the principles described by Boyle et al(2010), they enter into an arena where they can be in a reciprocal relationship with a service user. They are not necessarily in charge or taking the lead. The Practitioner Trainer's assets and capabilities, such as their professional knowledge, can be recognised and used to best advantage, towards a mutually advantageous goal determined by all parties.

The focus of empowerment through co-production is the citizen/ service user, but our Practitioner Trainers also described benefits to themselves including 'authenticity', 'depth' 'disclosure' and 'support'. Recognising the service user as an expert allowed participants to become more flexible in their own practice, to take a step back from

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'managing' the situation. In order to facilitate a workshop that was rich in content, with a foundation in service users' experience, both parties had to be able to express needs, give feedback and listen to the other's interpretation of the experience. Co-production described here is an example of 'mutuality': a mutual exchange or best deployment of shared social capital as described by Brown (2016), whereby professionals and service users both bring valuable assets to the social encounter and contribute to a product (in this case a workshop) or value to them and to others. It is also an example of 'recovery together', as proposed by Fisher and Lees (2016). In the co-trainer relationship, both parties had social capital to share, and the collaborative relationship enabled new narratives of recovery to develop (and extend beyond the Recovery College setting). Rather than working together on the service users' 'problems' according to the standard linear recovery narrative of 'getting better', both parties in the Peer and Practitioner collaboration used their expertise and experience for mutual benefit.

While Fisher argues that therapeutic encounters may be the site of transformation for both parties, made possible by an openness to less restrictive narratives, it must be acknowledged that the Recovery College workshops were not overtly therapeutic encounters. This was an educational space, with trainers co-producing educational workshops. Participants described a transformation of their professional practice subsequent to Recovery College involvement, but perhaps this had to begin in a non-clinical setting, with clinicians stepping into an educational rather than clinical role. This allowed them to learn to collaborate on an equal footing, even when the Peer Trainer might be known to them as a service user in their clinical practice. They came to the Recovery College because of their expertise by experience as Practi-

tioners, but were not expected to be professionally responsible for direction or ownership of risk, as might be the case in their clinical setting. In co-production the experience was 'facilitated' not 'managed'.

The 'shift in power dynamics' the participants described was not always comfortable or immediate. Participants described a gradual ease with co-training, however there was discomfort when their co-trainer presented with signs of mental illness. At those times there was a conflict or at least negotiation of roles. It would be unrealistic to ignore the differences between Practitioner Trainer and Peer Trainers, where one person has chosen to follow a career which involved study and practice to obtain their experience and learn to help people. The other person, beyond their control, may have experienced mental distress, crisis, loss of identity and challenges from treatment (in some instances individuals may inhabit both roles but the Recovery College ethos is that each workshop has a Peer and Practitioner co-trainer). In this study participants found benefit in both experiences, echoing Shepard et al (2010).

In this study we have identified a factor that might inhibit the transformation of professional-service user relationships towards full 'mutuality' or 'recovery together.' Participants described times when they were concerned about their co-trainer's mental wellbeing. Interestingly they approached this not as a clinician would, but as a colleague, supporting the notion by Bradley (2015) of co-produced recovery working moving people on from the sick role by recognising their strengths and self-management techniques. This became more problematic in one case when the Peer Trainer was known by the Practitioner Trainer in a clinical role, where there was a different level of accountability toward the service user's care, as identified by Boyle

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& Harris (2009). A crucial question in the development of co-produced services may be how to address a conflict of interest when a Practitioner Trainer is the treating clinician of the Peer Trainer. One approach may be to make a collaborative agreement at the outset as to how concerns will be raised and respect will be upheld. As Meddings et al (2014) suggest, this changes the relationship from a hierarchy to a partnership. Similar standard practices can be seen in teaching when the whole group makes 'ground rules' or in steering groups with 'terms of reference'.

What this study adds to the evidence?

This study demonstrates the potential of co-production in the Recovery College setting to transform Practitioner Trainers' perspectives on their professional role and relationships with mental health service users. Core components of co-production were present in their accounts of Recovery College working: reciprocity, mutuality, support and best use of assets. Recovery College experiences changed clinicians' attitudes to story sharing, use of language, and collaboration. Recovery College working altered clinicians' perspectives on their professional roles because in this context it was appropriate to model openness, self-disclosure and seeking support. The health co-production literature so far has focused on the transformational potential for service users but not for clinicians (Slay and Stevens, 2013). Where co-produced education has been evaluated in mental health (McGregor et al, 2014; Davies et al, 2014; Spencer et al, 2013) the professional perspective has been given but not explored in detail. Our study suggest some of the mechanisms by which co-production may redefine professional practice: being in an educational rather than clinical context, the experience of being supported, the challenge of negotiating multiple roles, including that of being a colleague to someone with mental health needs, and the

experience of a gradual shifting of role emphasis as the co-trainer relationship developed. This seems to be an example of what Fisher and Lees (2016) call 'recovery together', where the distinction between professional and service user recedes.

Whilst evaluation of the benefit for mental health service users of Recovery College initiatives is of course of paramount importance, we must account for the impact on Practitioner Trainers, both in terms of their approach to education and training, but also their subsequent attitudes and approaches to their clinical roles.

Limitations, strengths and further work

As far as we know, this is the first published research to focus solely on the effect of Recovery College working on Practitioner Trainers. It should be a starting point for further research, not least to determine whether the experiences described here are common or unique to this one particular organisation. Participants here were all relatively senior clinicians, who volunteered to take part in the study. They may not be typical Practitioner Trainers, or typical mental health clinicians, but rather 'early adopters' or champions of the Recovery College approach. Further research should include interviews with a wider range of Practitioner Trainers, with more varied career trajectories. Future research might also explore Practitioner and Peer Trainer perspectives on the same workshop encounter or working relationship, to compare and contrast their perspectives.

Conclusion

This exploratory study offers insight into the Practitioner Trainer perspective on co-production in the Recovery College context. We agree with Fisher (2016) that the clinical practitioner experience of co-production is more than just joint decision mak-

ing. In addition it can be a power sharing experience, with a potential outcome that could reduce stigma and reduce powerlessness if done effectively. Co-producing workshops in a Recovery College provided an opportunity for clinicians to learn different approaches to their clinical and managerial practice. This learning was founded on a recognition of service users as experts and of the idea that listening to their narratives could guide collaborative decision making and planning. The practice of co-production assisted clinicians in developing more effective communication skills, such as changing the use of jargon. As an initial exploration of 'the meaning of co-production' for Practitioner Trainers, the findings of this study must be tested against Practitioner and Peer Trainer accounts from other colleges and in other forums for co-production.

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