The magic of co-production in the making of a Norwegian recovery college: a qualitative case study

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Abstract

Background. This thesis is a qualitative case study of a recovery college project in a Norwegian municipality and places itself within the field of intercultural studies and particularly within the area of intercultural health. Recovery colleges' aim is to facilitate recovery among students living with mental health and/or substance dependence issues, by bringing a diversity of competencies ('by education' and 'by experience') into interplay within the same organizational space, seeing them as complementing each other. Previously held ideas of effective recovery and social integration are changing due to the recovery movement and philosophies that prioritise holistic wellbeing and personal and social recovery and empowerment. Those traditionally perceived as service users are increasingly recognised as of being equally and uniquely competent to judge and steer their own recovery journeys relative to educated health professionals who have usually held the power and authority in organisational and institutional settings. This power vested via broader societal structures, positions and related 'competencies,' is challenged by co-production methods. Co-production is understood as the 'magic' ingredient which makes the recovery college special and is viewed as a key for introducing societal and systemic change.

Objective. I explore the recovery college settings through the dynamics of agency and structure, with emphasis on the diversity of competencies in co-production, as an equalizing tool for recovery-oriented working. I am interested in the rationale behind the recommendations of and employment of co-production in the services, the impact of co-production on recovery-orientation and what recovery is considered to imply among the parties involved, not least how the parties approach these issues. Moreover, I explore how their interactions and conversations in these respects reflect prior experiences, positionality and discourses central to our times, such as the issue of integration in overall society, ethnic and cultural diversity, Norwegian ideals concerning cultural "sameness," how competencies are valued, and stigma processes.

Design. The case study design uses data collected through personal interviews, participant observation and co-production as in participatory action research. In total, 26 participants with diverse competencies and backgrounds who were involved variably in the development of the Bugard recovery college project were interviewed in either formal or informal interview settings. Data from the project pilot via feedback from the first run of students is also analysed.

Result. Co-production processes and interactions between individuals in these settings are seen to be affected and influenced by a variety of factors. The innovative and radical nature of co-production has been for the most part experienced as positive by those involved in project development and by the students in the pilot. I identify that one agenda behind the employment of co-production in the services is to redirect a potential insular orientation among persons with mental health and/or substance dependence backgrounds towards societal integration and active citizenship. Likewise, I identify a desire to create shared understandings and values and facilitate partnerships across asymmetrical relationships and otherwise differently positioned actors in the health sector. I find that although co-production is considered an equalizing tool, there still exists wider cultural discourses around stigma in mental health and societal integration, structural hierarchies and diverging ideas around the college's central ideologies of recovery and differences in decision-making power and authority between 'experts by experience' and 'experts by education'. These factors have a rich context outside of the co-production space and have all been seen to influence the recovery college environment, and have had a measurable influence on both the experience of co-production for various parties and the types of 'products' or content produced throughout the development the recovery college project.

Clarification of terms

The municipality of Bugard is a pseudonym for the actual municipality I undertook fieldwork in for purposes of research ethics (see Ethical concerns: Deidentification under Methodology).

Co-production/co-production settings refer/s to the cooperation, skill-sharing and mutual involvement of variably positioned or competent/skilled individuals (namely 'experts by education' and 'experts by experience') working together on the recovery college project.

Competence by education/ education-based competence refers to competence or skills gained through the traditional pathways of education and work. The equivalent Norwegian term is *fagkompetanse*.

Competence by experience/experience-based competence refers to experience gained through what is often termed 'lived experience' of diverse challenges that occur throughout life and the process of dealing with these. In this thesis it refers specifically to competence or skills believed to be gained via the experiences of challenges with mental health or substance use, as it is often used in official policy in various Norwegian settings. This competence may or may not be 'verified' or added to via education and or skill development programs, however is to be taken as a valid form of competence on its own and of equal value as competence by education. The equivalent Norwegian term is *erfaringskompetanse* but the term *brukererfaring* (user experience) is also common.

Expert by education: individual employed in a professional role on the basis of having traditionally acquired educational competence, such as a university degree and work experience. Common examples from the field include psychologists, nurses, municipal consultants. The term 'expert by education' is adapted from an English recovery college program. It is also a (non-literal) translation of the Norwegian word *fagperson* which was a term used by participants in this study to refer to someone with *fagkompetanse* and differentiate them from those with *erfaringskompetanse*. It is shown with quotation marks to indicate that these are the terms that were used in this study, however are by no means the most common or appropriate terms outside of this research context.

Expert by experience: someone with experience-based competence. Used with the same considerations as 'expert by education'. Those employed on the basis of this kind of competence are referred to variously in Norwegian research literature as *brukermedarbeidere, medarbeidere med brukererfaring* and *erfaringskonsulenter* which have similar meanings, however the term 'expert by experience' specifically refers to the types of roles and settings seen within this study.

Experience consultant – a specific job title found in many municipal and other public sector departments. Refers often broadly to an employee with own experience within mental health and/or substance dependence issues and can encompass a wide range of positions/work tasks which are not necessarily unique to that position.

Service user: broad term for individuals in diverse groups that utilise services under the mental health and substance use service umbrella. These include those in active treatment for mental health or substance use challenges, those attending activity centres or participating in a wide variety of programs. While the term service user has been described to be potentially negatively loaded, I have sought to use with reference to individuals who utilise and are the target group for a variety of *services* offered by health and social welfare systems. It is not intended to refer to 'user' with the negative connotation of one who uses illicit substances.

'Service user' also does not suggest inherently what that individual is using the service *for* and implies potential for agency in contrast to the more passive 'service receiver'. It is more useful in this context than 'patient', which suggests a wholly clinical relationship. It also is used to distinguish from those within the target group for the recovery college project, who have a diverse range of competencies and use (or do not use) a diverse range of services, and those working *on* the project who have lived experience *of* service use in many cases ('experts by experience').

Note on potentially negatively loaded terms: I have tried wherever possible to use as neutral as possible language and often use terms such as 'individuals with mental health challenges/issues' or 'individuals with substance use issues' to refer to these issues rather than 'mentally ill', 'drug users', 'substance users', 'addiction', 'substance abuse', et cetera. Substance use disorders are a valid form of mental illness; however it has been necessary to differentiate in certain cases between the two. In other cases, 'mental health issues' is taken to refer to problems related to mental disorders and challenges more generally.

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Chapter one: Introduction to the study

The municipality of Bugard in Norway has embarked upon an ambitious project which is considered ground-breaking for the Norwegian context, that of creating a recovery college, modelled after previously established models in the United Kingdom and abroad. The major idea behind recovery colleges that differentiates them from other educational programs and recovery-oriented, interdisciplinary health-educational therapeutic initiatives, is that of a radical interpretation of 'co-production' between health professionals and individuals with lived experience, experience consultants and caregivers. Co-production is understood as the 'magic' ingredient which makes the recovery college special and is viewed as a key for introducing societal and systemic change. Co-production is to be enshrined at all levels of the college's organization and in all activities in the making of the college – throughout planning and development, and in execution and management of the established college. This has also involved shared competence building between the parties on the way, with both sides involved in idea selection, development and delivery (i.e. teaching) of the college's co-produced curriculum. Another key goal of Bugard municipality was to have a diverse mix of competencies in terms of course receivership, as 'experts by education' and caregivers amongst others were encouraged to take part as students, not only current service users. This dissertation takes this recovery college project as a case study, situating it within the research field of intercultural health, and examining and analysing various co-production settings during the stages of the development process from beginning sketches and brainstorming during meetings in early 2018, through to and after the first 'pilot' semester commenced in 2019. The study engages with various themes and discourses that have become clear while researching the relatively new and unique co-production process the municipality has established, and how these methods and experiences have created a new kind of organisational culture that the study's participants are operating within.

When the municipality embarked on this process, around 70 such colleges were already operating in Great Britain, and the municipality has adopted many cues from these forerunners. However, co-production within the frame of recovery colleges has to little extent been made an object of study. Filipe, Renedo & Marston (2017) argue that the co-production process, its meaning and the concrete settings in which co-production occurs, are open to variegated interpretations, with the term co-production being used in a variety of organisational settings to refer to different processes. During my initial meeting with the municipality of Bugard, I was informed about the project and key sources, from the municipality's own recovery-focused

work so far, recovery colleges in Nottingham and London, and the plans to create a similar project using inspiration from a variety of models in Bugard. It was emphasized that recovery-focused services such as the recovery college within the municipality worked along the principle stated in the motto *Ingenting om meg uten meg:* in English: “Nothing about me, without me,” which has become a common catchcry across many departments within the Norwegian health sector with reference to recovery-oriented changes (Knudsen, 2015; Pasientsikkerhetsprogrammet, 2016). In interviews and conversation with key representatives at the board during the earlier stages of development in 2018, it was clear that the Nottingham recovery college model (hereafter referred to as the ‘Nottingham model’) would be the basis of Bugard’s project. Bugard’s program developed at the forefront of an innovative period in which a few municipalities launched recovery college plans.[1] I was fortunate to be able to follow the process since my own fieldwork began in March 2018 when the planning was still in the early stages.

Research motivations

My research was motivated by several themes. Coming from a multidisciplinary background including criminology, psychology, intercultural studies and the history of mental health gave me a particular interest for undergoing research into the circumstances of people struggling with mental health and substance dependence issues and resulting stigma and discrimination both in everyday life and in interactions with the health and social welfare systems at large. Undertaking this research would allow me to examine how the mental health field has changed over time, and the framework of recovery has been a particularly radical movement within health research in recent years, in a field which still carries connotations from a past associated with institutionalised confinement, isolation from society and harmful treatment (Foucault, 1975:199). Despite many positive developments across the past decades, including the recovery movement (Slade, 2014:72) the mental health field still faces challenges in assisting those in need of its services, meaning new methods, further research and different perspectives are in demand (Pettersen & Lofthus, 2018:118). Stigma and discrimination around mental health issues are continually major issues that affect recovery and social wellbeing (Mezzina et al., 2006:41). Norway has comprehensive and publicly funded social health and welfare schemes which contribute to one of the highest living standards in the world, with government policies that generally reinforce the need to support disadvantaged and vulnerable members of society, such as the unemployed or those with mental health challenges (Borg & Kristiansen, 2008:513). However, statistics show that rates of mental illness and substance dependency

(both of illegal and legal substances) are still high in the Norwegian population, including increases in recent years in certain populations, such as among young women and individuals with immigrant backgrounds (Reneflot et al., 2018:8).

With regards to the latter, Norway experiences high levels of immigration and statements in official policy and the growing precedence of initiatives locally promote constantly the importance of integration and societal participation (cf. Eriksen, 2013; Thorud, 2018:8-10). This can broadly apply to those experiencing mental health and/or substance use challenges, or those who have immigrated from another country and culture. Developing of a case study around a project such as the recovery college in this context allows for exploration and examination of the themes of integration, culture, stigma and what types of 'competence' are needed to be a societal participant and how they are developed, shared and taught within this space. A strong motivator was also having the opportunity to potentially affect positive change within this project going forward, and the mental health services on a broader scale, by conducting research that could assist in providing feedback to the college group on experiences of co-production and project development. This was also a key factor in the decision to undertake action research (cf. Trotter and Schensul, 1998:693) when the opportunity arose later in the fieldwork process, which I will discuss in chapter three.

Potential gaps in the existing literature

Another important consideration was that while the field of recovery scholarship generally has grown significantly in recent years, actual research on recovery colleges as a concept and how they work is quite new and relatively limited, particularly within the Norwegian context where the concept is very new. Some international studies have been undertaken. Arbour & Rose (2018) argued that recovery colleges overall are positive in transforming hierarchical health systems and provide a radical "paradigm shift" in attitudes within the health sector and also in user-provider relationships. McGregor, Repper and Brown (2014) argued that the specifically education-based perspective versus health or clinical perspectives, along with co-production, was one of the main strengths of the Nottingham model. Bourne, Meddings & Whittington (2018) found a link between reduced overall health service use and recovery college attendance, with contact with health services.

Other studies include Meddings, Byrne, Barnicoat, Cambell & Locks (2014) and Zucchelli & Skinner (2013). Perkins, Repper, Rinaldi & Brown (2012) again focused on the positive impacts of the educational (the 'college' part of a recovery college) versus health-

oriented perspectives in improving recovery outcomes. Other researchers have studied other alternative, or competence-building/skill-focused (in contrast to medical/clinical) therapies in the context of recovery. Solli, Rolvsjord & Borg (2013) found that music therapy was beneficial to mental illness recovery through many of the principles in personal and social recovery (as defined in chapter two). Makin & Gask (2011) also found that art-based therapies aided in recovery processes where solely clinical or therapeutic interventions fell short. While helpful in providing insights into the experiences of students of already established recovery colleges and overall 'recovery impact', there is little data on emerging or still-developing colleges, particularly outside of the United Kingdom. Studies on artistic or alternative therapies with a recovery lens are significant for the overall field but lack the particular 'educational' framework of recovery colleges that adopt the methods described most commonly in the United Kingdom studies. There is also a need for research on the processes used in the development of recovery colleges, such as co-production and the utilisation of experience-based competence, and how this is experienced in the day-to-day organisational realities of developing a project, as in Askheim (2016).

Research questions and the purpose of this study

The purpose of this case study is to explore the many facets of the phenomenon of co-production during the project phase of the recovery college. How has the process of co-production within the recovery college itself, but also prior to its inception and in the wider context of 'experience-based' competence's inclusion in the health and social welfare services, been experienced by actors with diverse competencies? How do these experiences translate into the recovery college co-production settings? What makes the recovery college unique, special and/or necessary for Bugard municipality and how do the participants envision the project and its role within the structures that exist today, and especially with respect to promoting recovery?

Different interpretations of, and experiences with co-production are explored, and the larger issues they evoke, whether in conversations and interviews, in the course of social interaction in co-production settings, or in terms of official statements and municipal policy. The recovery college is geared on overcoming otherwise recognised asymmetries in terms of relationships and competencies between the parties involved in co-production efforts. In the thesis I explore the paradoxical dimensions involved in the creation of an egalitarian space within the frame of an otherwise hierarchical municipal structure. When exploring the 'microcosm' of co-production settings, it becomes increasingly clear that what goes on in these

must be interpreted through the lens of wider, more ‘macroscopic’ contexts. Hence, the thesis raises numerous questions (in which each would deserve a thesis on its own), such as: What is the relationship between the recovery philosophies promoted by the different parties involved in co-production - and the issue of normative integration in overall society? How does the ideal of co-production reflect ways in which Norwegians tend to think of equality in terms of “sameness”? In the light of the increasingly culturally and ethnically diverse context of Bugard municipality, with a steadily increasing immigrant population, settling of refugees and officially established concern for further social integration of various vulnerable and stigmatised groups, how will the recovery college be placed to assist and address these concerns? What does the actual framing of diversity in co-production tell about processes of inclusion and exclusion? All in all, co-production evolves at the crossroads between agency and structure and becomes a lens through which the themes of integration, stigma processes, cultural diversity, equality and hierarchy are explored.

Chapter outline

Chapter two presents the theoretical grounding informing this study and seeks to give an overview into some of the major scholarship within the interdisciplinary research field. I discuss the central themes of co-production, competence and knowledge; recovery; the relationship between agency, structure and systemic operations within social and cultural contexts as seen through the lens of the social field; stigma and discrimination; and lastly intercultural communication discourses.

Chapter three discusses my study's methodology, the methods of data collection used in my fieldwork, ethical considerations and some reflections on the overall experience of fieldwork.

Chapter four delves into structure, hierarchy and systems as theme, and seeks to contextualise the complex nature of the Norwegian healthcare and social welfare system with reference to agency, structure and systemic operations and their impact on the positioning of actors within the research context. I contextualise the study within changes in the Norwegian political landscape which have impacted healthcare and social welfare policy, the development of recovery-oriented working leading to the establishment of the Bugard recovery college; and some particular challenges that these fields have faced with particular relevance to the overall themes of the study such as integration, stigma and recovery.

Chapter five establishes the origin of the 'magic' in this dissertation's title and its relationship to co-production and recovery principles and explores prior experiences with co-production as related by experience consultants, in order for this to service as context for interactions in recovery college settings.

Chapter six looks at co-production within the settings of the recovery college itself. The focus is both on important decisions to be co-produced - such as the choice between 'a school path' and a 'health path' - and on the co-production of content. I also look at some of the restrictions placed upon role shed and co-production as an equalising tool, especially regarding legal ramifications and bureaucratic pressures such as "time to do".

Chapter seven explores processes of stigma and self-stigma and discrimination that co-production and overall recovery philosophy seek to counteract and break down at both individual and systemic levels.

Chapter eight discusses wider issues related to integration and how it relates to recovery, culture in various forms, and questions the role of co-production and the recovery college in the broader landscape of the Norwegian welfare state, political and sociocultural shifts internationally, discourses of diversity at ethnic, linguistic and cultural levels and what is often taken for 'normative' social integration and cultural life. The final section of the thesis is devoted to concluding reflections and findings from my study, potential areas for further research, and attachments.

Chapter two: theoretical foundations of this study

Introduction

The central theme of this thesis revolves around co-production based on the interplay between 'competence by education' and 'competence by experience'. The main idea is that for a service to become truly recovery-oriented, it cannot simply be based on views and evaluations of clinical outcomes and 'best practice' stemming from competence by education, but must also incorporate what those using and with experience of using the service themselves believe will contribute to recovery, as they themselves define it (Bøe, 2007; cf. Pettersen & Lofthus, 2018; Toverud, 2015:8). In the context of the recovery college project, participants are expected to be involved on equal terms regardless of their level of education or type of experience and background (competence), despite the fact that the health sector can otherwise be experienced or described as hierarchical and composed of asymmetrical positions and relationships in which professional and educational competence plays an important role (Askheim, 2016:25). This dilemma will be engaged with in the context of the unfolding of the Bugard recovery college project at the crossroads between structure and agency (Ortner, 2006). In this theoretical outline I approach the major issues that the recovery college project evokes and around which this thesis revolves. Theoretical perspectives may illuminate special features such as the method of co-production as a tool for potential cultural change, and the impact of dynamics such as stigma and self-stigma on interactions between individuals in organisational settings. In the following I will outline aspects of models of recovery, the framework of field, capital and habitus, theories about competence and skills, the concepts of stigma, including self-stigmatisation and social marginalisation, and concepts of intercultural integration and communication, as this study examines many examples of communication and interactions between individuals and the dynamics of these. I will also touch on other theories, such as definitions of organisational theory, that are useful for culturally interpreting the research context. The theoretical constructs in this chapter are by no means the only useful conceptualisations, however I have tried to represent a range of models and theories that inform my case study and the wider scholarly landscape that this thesis organises itself within.

On recovery

The central aim of any recovery college is to facilitate recovery. What should be understood by recovery? It is crucial to sketch out the major ideas and developments within recovery research, in order to understand 'recovery' as it is understood both within this case study and how the recovery movement positions itself within the wider field*s* of public health and society. Most recovery approaches define recovery as a philosophy or a process or journey, not as a

"cure" for mental illness or achievement of a state without symptoms or limitations, as in Deegan (1996) in Borg, Karlsson & Stenhammer (2013:12). Recovery is typically viewed as process and not as an end result or a polarisation of 'before and after' states, but focuses on coping with symptoms in addition to a meaningful and overall positive everyday life, positive relationship with one's self and participation in activities such as work and education (Borg & Davidson, 2008; Landheim, Wiig, Brendbekken, Brodahl & Biong, 2016:19-27; Lofthus et al., 2016). Longitudinal studies have for decades shown that recovering from mental illness is possible for many with or without medicalised interventions (Borg, Karlsson and Stenhammer (2013:9), prompting researchers to question the effectiveness and necessity of traditional clinical methods alone, and how best to meet the needs of those entering the system.

Research emphasises that user participation and recruitment of employees with own lived experiences within the area of mental health and/or substance dependence have clear improvement gains through counterbalance to professionalisation and hierarchical power systems in psychiatry (Borg & Karlsson, 2011; Borg et al., 2013). Nyttingnes (2008) found that "user employees" can provide equivalent or better help as "professional employees", regardless of treatment method (see also Middleton, Shaw, Collier, Purser & Ferguson, 2011; Biong, 2015). Researchers suggest that the relational processes, or dynamic interplay between competencies, make for significant change, regardless of treatment (cf. Borg, Jensen & Topor, 2011; Landheim et. al, 2016). "User employees" have also been found, to a greater extent than 'experts by education'/"professional employees", to emphasize the entire person in his or her daily life inside and outside the services and thus to a greater extent emphasize personal and social recovery perspectives in addition to the purely clinical (Borg et al., 2013; Jensen, Borg & Topor, 2010).

Researchers have also argued that the traditional medical models of mental illness do not explain recovery processes *or* the causes of mental illness sufficiently (Tew, 2005, in Schön, Denhov & Topor, 2009): The concept of social and personal recovery has taken increasing precedence in public health policy and research in recent years (Borg et al., 2013:9). The increasing interest in recovery from personal, social and holistic perspectives and the development of a variety of models has been linked in part to the deinstitutionalisation and antipsychiatry movements, as well as increased focus on user involvement, salutogenesis[2], human rights within mental health, and empowerment (Borg et al., 2013:19). A variety of scholarly definitions are available, including that by Anthony (1993:17):

> Recovery is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (Anthony, 1993:17, in Borg et al., 2013:10; Slade, 2014:38).

Other approaches to defining recovery from British scholarship include "…recovery is about creating a meaningful and peaceful life, as the persons themselves defines it, with or without symptoms and problems that can come and go" (Shepherd, Boardman & Slade, 2008:1) and the more concise "Recovery involves living as well as possible" (Slade, 2014:38). The Scottish CHIME[3] model was also a popular frame of reference for the Bugard recovery college project, although it was not used in the ultimate program design, and promotes five elements to recovery: connectedness (through social relationships); hope; identity; meaning and empowerment (defined as taking responsibility for and having a sense of control in one's life) (Scottish Recovery Network, 2019). It is designed as an institutional framework through which mental health service providers and users can communicate more effectively about the user's desires for their own recovery and what resources they can draw on and further develop in line with these categories. For example, connectedness refers to "Having good relationships and being connected in positive ways to other people. This includes peer support with people with experience of mental health issues, as well as relationships with carers, friends, and family", as well as one's relationship with health professionals (Leamy, Bird, Le Boutillier, Williams & Slade, 2011).

Definitions and goals of recovery align with comments about the meaning of recovery as expressed by many of my informants, as will be discussed later in the thesis. When the term 'recovery' is used henceforth, it is referring to both these definitions of "personal recovery", but also "social recovery". Effective recovery approaches must integrate the social life and context of an individual and is associated with inclusion and integration not only via the restructuring of self but also through social experience and "citizenship" in society (Mezzina et al., 2006). Personal recovery theory is generally centred around hope, belief in oneself, meaning, and mastery/sense of control, as in Borg et al. (2013:11-12). These principles were also central to the Bugard recovery college.

Most of the key developments in recovery scholarship revolve around similar concepts: the transition from primacy of clinical and biological markers of rehabilitation and wellbeing; the reorientation of 'control' and decision-making authority from the hands of 'experts' such as psychiatrists and doctors to the patient or service user themselves; empowerment; autonomy and a solidification of a broader idea of what 'recovery' means in social, cultural, medical and economic contexts. Recovery scholarship also tries to expand recovery 'in practice' outward into all aspects of an individual's life, attempting to build a satisfactory life for the individual by considering many different factors, where illness is only one element in a person's identity (Davidson, O'Connell, Tondora & Lawless, 2005). Many of the criticisms or cautions levelled in the research literature are about how recovery is implemented into existing health and social welfare structures without simply becoming a 'rebranding' of traditional models, or by placing the onus and responsibility for recovery entirely on the individual, rather than establishing a cooperative partnership towards that individual's recovery goals (Shepherd et al., 2008). The ground idea upon which the recovery college model is built is precisely that of 'co-production' between equal parties across the divide that otherwise is conceived to exist between service users and professionals. One of the ways this has been combatted in 'recovery in practice' is through involvement and employment of individuals with lived experience of mental illness and substance use or 'competence by experience' which will be discussed in the next section of the chapter. They play, as we shall see in this thesis, a crucial role in the recovery college project.

Competence

Typical Western societies ascribe value to what is viewed as a normative pattern of gaining of skills and competence (Husu, 2013). In Norway in particular, high standards of academic achievement have become more normalised[4]. Education and employment, i.e. competence, are tools for achieving social and cultural capital in Bourdieu's (2006) terms and bettering one's position, in the general fabric of society. Bruun, Jakobsen & Krøijer (2011) argue that Scandinavian traditionally "egalitarian" societies tend towards "value-mastering hierarchies", wherein individuals learn in everyday spaces what is expected of a citizen – participating in sports or other cultural expressions, and learn the drivers of accepted cultural participation, which is linked to being an overall valued and normative person (see also Døving, 2009:10-11). The 'acceptable' is often more easily viewed by examining what happens when individuals fall outside the perceived norms, such as by experiencing mental illness or substance dependence problems. What the majority society deems to be 'success', cannot be

simply distilled to solely successfully completing education or attaining employment, but is a complex and changeable set of factors for which Bourdieu's (2006; 2017) framework of habitus, capital and cultural competence is useful in describing, as I will return to.

The recovery college concept is founded on the idea that 'experts by experience' (individuals with own lived experience) more easily understand the lives, struggles and aspirations of service users in recovery than do 'experts by education,' and that these two forms of competencies complement each other. All types of competence are in this environment in a sense marketable skills and tools for working in the environment of the health and social welfare departments. We can look to Dubois and Rothwell's (2000) definition of competence for a concrete outline:

> …Competencies are the tools that employees and other persons use for effective performance, regardless of the performance setting. Competencies [are] the knowledge, skills, values, social roles, and other characteristics that an individual uses in appropriate ways, to produce some product or render some service to meet the needs of a customer, client, constituent, or some other person. This definition has a significant corollary: not all human characteristics are competencies. A human characteristic is a competency only if it can be shown to be required for successful performance (Dubois and Rothwell, 2000:3.7).

Klingsheim (2016:33) argues that professionals can monopolise certain types of work tasks, and are given authority to do so, through the politically constructed nature of professional employment as a "societal contract": "that state gives more or less exclusive rights to that group of professions for undertaking the work on behalf of the community". Inherent trust of mental health professional's competence as leading over both the insights and in some cases, autonomy and agency to make decisions has been shown to be problematic for both parties, resulting in stigmatisation and discrimination (Slade, 2016:29) and poorly matched treatment (Sells et al., 2014). Trust in the dominant professional perspectives is linked to traditional reliance on evidence-based perspectives in health practices (EBP) which in itself there is a disagreement around what specifically constitutes evidence, whether it is research or clinical expertise (Bøe, 2007). The Norwegian Psychological Association defines EBP as: "the integration of the best available research with clinical expertise, seen in the context of the patient's characteristics, cultural background and wishes." (Kaur & Naseem, 2017:3) However, these perspectives can be experienced by service users as negative when combined with

compulsory treatment, for example. A study by Stensrud (2016) found that compulsory treatment was experienced as a hindrance to further social integration after the experience of being psychiatrically sectioned, which was a barrier to overall recovery.

The term experience-based knowledge is based on Aristotle's philosophical conceptualisation of three equal knowledge forms, theory, practical and experience-based (Lundstøl, 1999, in Klevan, Sjåfjell, Borg & Karlsson, 2018:16; Adloff, Gelrund & Kaldeway, 2015:8). Despite the growing body of scientific evidence of the relationship between structural factors such as income, social inclusion and physical health and mental health, EBP frameworks of identification, diagnosis and treatment of specific illnesses is often prioritised, especially in the specialist psychiatric services (Klevan et al., 2018:17; Slade, 2014, 14-15.) The definition of theory-based competence is more readily understood, whilst experience-based competence comes from the lived and bodily 'experience' of human life:

> To experience is to get to know, sense, come to terms with, understand, recognise… experience reflects on authority, wisdom, life and human knowledge and majority. Experiencing involves exploring and investigating for the purpose of wandering". (Klevan et al., 2018:17)

They define experience-based competence further as follows:

> With experience-based knowledge are lived experiences understood and acknowledged as competence. This experience-based knowledge creates an important and equally valuable competence form as other competence forms such as practical and theoretical knowledge (Klevan et al., 2018:16).

This understanding of the creation of knowledge through lived – both physical and mental – bodily experiences within the social world acknowledges that experiences not related to the pursuit of theoretical or practical expertise do not occur in a vacuum and reflect the concept of tacit knowledge originally coined by Polyani (1966, in Adloff et. al., 2015:7-10). Tacit knowledge refers to a variety of questions and challenges within diverse disciplines and settings around different types of competence such as knowledge management in organisational settings, intercultural communication, or creative practices (Adloff et al., 2015:7-10). It can refer to skills expressed in bodily actions such as creative performances or conducting experiments, but also reflect culturally relevant intuitions and assumptions that influence individuals' reactions and interactions with their social world and can be said to all

actions, behaviour and knowledge production (Adloff et al., 2015:7-8). Adloff et al. (2015:9) argues that the Aristotelian conceptualisation of the three forms of knowledge is possibly the first systemic classification of the differences between propositional, or theoretical knowledge, and intuitive and experiential forms of knowledge, however Western philosophy of knowledge production maintains a longstanding traditional bias towards propositional, demonstrative knowledge, leading to a desire for scientific validity. This shows a preference for the learned and demonstrable over the innate, as tacit knowledge cannot be verified in the same way as propositional knowledge (Adloff et al. 2015:7-10). This can result in the preferencing of evidence-based scientific knowledge, yet many scholars have also theorised that scientific and evidence-based research is not purely objective, existing only within the borders of rationality; Adloff et al. (2015:9) quote Polyani and others who challenged this idea, arguing that theoretical or scientific knowledge is also itself "embedded in social contexts and thus also depends on the tacit knowledge of social actors". Slade (2014:18-20) reinforces this view with reference to psychiatry, referring to the shifting nature of the DSM diagnostics manual as an example which demonstrates even diagnosis of mental illness is not neutral in nature, it "directly impacts on social understandings of human experience" and "reorient our thinking about important social matters and affect our social institutions".

Bourdieu on social field, forms of capital and habitus

This thesis is inspired by Bourdieu's (2013[1977]) concepts of field, habitus and capital which serve to highlight the relationship between agency and structure and frame some of the social and cultural aspects of the research field studied and its participants' positioning. Bourdieu (2017) stresses that in our dealings with others (groups, organizations, the state) we are subject to classifications and evaluations. We participate variably in different social fields, in terms of differently weighted and evaluated social capacities. Among other things, level of formal education, work, economic assets, taste and lifestyle, social network and family figure among the factors that greatly influence social status, access to and competition within social fields (Husu, 2013:265). The concepts of social field, capital and habitus allow examination of power structures that give meaning to social interaction (Goetze, 2017:16). As observer or researcher, one looks through a kind of "peephole", identifying fields through relations and positioning of actors within (Goetze, 2017:17). Social capital and cultural competence are interrelated within various social fields (Husu, 2013, 264-265). The field or social arena is defined as "a set of objective and historical relations between positions" (Bourdieu & Wacquant, 1992, in Husu, 2013:266). Various interactions between diverse social actors within fields can be viewed as

structures which are made up of differences between these actors (individuals, groups, institutions of various kinds), while the *positions* in the field of these actors (social agents) are based on distribution and possession (and conversely, lack of) various types of capital (Husu, 2013:266). Goetze (2017:17) states:

> Fields are established by the weaving of webs of direct and indirect relations between actors in the field, and by their competitive and distinguishing practices. These relational webs form a microcosmos in the larger universe of society. Social actors are embedded in many and multiple relations and, hence, in many and multiple fields.

Hence, the structure of the field and asymmetrical positioning of those situated within it are interrelated, as to the varying types of capital that actors possess or can attain in order to 'move' positionally within the determined structure of the field (Pinxten & Lievens, 2014). Capital refers in a quite literal sense to economic wealth, however Bourdieu (2006) also expanded his concept of capital to include cultural and social. In late modernity, argues Bourdieu, class takes on the imagery of lifestyle and taste, and social capital refers to the "[aggregated] actual or potential resources which are linked to the possession of a durable network of more or less institutionalised relationships of mutual acquaintance and recognition" (Bourdieu 1986, in Pinxten & Lievens, 2014:4). Bourdieu gives weight to patterns of consumption, cultural interests and competencies and academic capital in his analysis of the "education society" and "consumption society" which reflects on Marxist understandings of "class as the background for oppression, conflict and struggle" (Danielsen, 2013). Cultural capital is defined via three strata – institutionalised cultural capital via educational attainment; objectified cultural capital via acquisition of cultural goods; and embodied cultural capital reflecting individual values, tastes, skills and knowledge or competencies of various kinds (Pinxten & Lievens, 2014). Actors with similar amounts of capital (cultural, social, economic) are closer to one another and in competition with each other in order to improve their own positioning within a particular social field, and in each social field or arena we find certain power dynamics (Pinxten & Lievens, 2014:3-5). Power is not an abstract resource in itself in the 'field', rather a consequence of the assigned values of different types of capital (Goetze, 2017:19). Capital is also not valuable purely through existence, rather it is ascribed worth by the actors within the field. through its recognition in the social field as important, influential or necessary.

Cultural capital via education is of more importance in certain educational and professional fields than others (Goetze, 2017:19). In the mental health services in Norway, protected titles such as psychiatrist, psychologist and nurse (Ringdal, 2015) based in ratified education give access to occupational statuses with distinct role repertoirs attached, as defined by law or increasingly by national and bureaucratic regulations (cf. Danielsen & Ludvigsen, 2014), by the organizational setting, relative to those of other professions and vis-à-vis that of patients. Competition between professionals (so-called *profesjonsstrid*) in this field is historically well known, for example with respect to diagnosing, decision-making and therapeutic interventions (cf. Slagstad, 2012).

Access to a social field such as that of mental health is also intrinsically linked to the habitus concept, which regards how structures such as institutions, relationships, resources and capital become internalised in that field's social actors' cognitive understanding and bodily comportment in a tacit way. The significance, therefore, of the behaviours and thoughts of actors is framed within "historically and socially situated situations of [their] production" (Bourdieu, 1977, in Husu, 2013, p. 266). The habitus explains the relationship between actors' ideas and behaviours, and their structural position within the field. The constrains of each field and the relationship between them and the habitus of the actors within them also impact wider collective movements in the social sphere (Bourdieu, 2013[1977]). The acquisition of capital and the potential to move more widely within a particular field by a certain group can be seen as a tool for changing the wider structural field.

Adloff et al. (2015) and Kaldeway (2015) highlight the importance of Bourdieu's theory of habitus (2013 [1977]) and practice for providing a more empirical structure for the issue of tacit versus other types of knowledge. Kaldeway argues that the concept of social field engages with the tacit nature of social interaction and tacit social knowledge, whereby actors within a field competing for various types of capital are guided by and share common background knowledge, by nature tacit, which contributes to the structure and reproduction of the field itself (Kaldeway, 2015:103-105). The field and habitus integrate with, influence and reproduce one another. The habitus is the embodiment of the social logic of the field, the "systems of… perception, appreciation and action that result from the institution of the social in the body", or the institution of and understanding of tacit knowledge of the social world or field within an individual body (Kaldeway, 2015:104). Amongst the participants in the recovery college project (all those involved more or less in the co-production, design and otherwise providing

input to the project at large) are individuals who have perhaps the experience of living at the 'margins' of wider society, or have experienced having reduced capital via having lived with mental health challenges and/or substance dependence for many years. We may expect these experiences to imply differences in language styles, bodily composure, habits and behaviour to those who are accustomed to prestige, economic standing and academic recognition, for example as a psychologist or psychiatrist. Kaldeway (2015:104-105) focuses on yet other dimensions of inequal power dynamics such as class, race and gender. He introduces the theory of cultural differentiation, a way of examining these dimensions through the lens of stratification. Stratification has similarities with Bourdieu's theory of capital and class, as it refers to the material resources, power, social and cultural systems that influence power relations between actors (Kaldeway, 2015:104-105).

Bourdieu's framework gives room to concepts of competence, in the sense of an individual being "qualified to participate", for example in political affairs, social or other cultural movements, which can also be defined as "cultural competence" (Husu, 2013:273). Husu (2013:273) argues that these competencies that allow individuals to take part in or influence these movements are based largely on privilege and resources, or capital. Here it is clear the relationship between social and cultural capital within one's social field, and the agency one has to participate in and motivate cultural or social movements or change. In the context of the recovery movement, competence by experience takes this role and assumes that lived experience of substance use, mental health issues and interactions with the health system in the role of patient produce a particular set of skills that one learns from their community, interactions with the system and by themselves to deal with the multi-faceted issues of recovery. These skills are related to those needed to successfully integrate or reintegrate into 'normal society' (Landheim et al., 2016).

Stigma: a construct within the social world

Krajewski, Burazeri & Brand (2013:1136) define stigma as inherently structural, with three main levels interacting with one another: institutional or structural stigma such as in state policy; interpersonal or social stigma in the general population or communities; and self-stigma. Stigma is recognised as a major barrier to recovery from mental illness, and has been linked to systemic discrimination, social exclusion, poor treatment access and poverty (Perese, 2007:285-286). Goffman's work on stigma explains that the term originates from the Greek term of the same name, used to refer to "bodily signs designed to expose something unusual and bad about the moral status of the signifier" (Goffman, 1963:5). These "bodily signs" were

marks (e.g. scarification) that were physically imposed on victims by authority figures in order to signify an individual's now-degraded social status to others. Goffman argues that the modern idea of stigma is used to refer to the "disgrace" itself, rather than some kind of marker of the "disgrace" (Goffman, 1963:5). Mental illness has long been associated in history with sinful behaviour and other forms of social disgrace, linking it firmly with the origins of stigma itself in religious beliefs and practices, which in turn have influenced social perceptions of psychological disturbances (Gullslet, Kim and Borg, 2014). To contextualise, the "disgrace" could be mental illness or addiction – others then (as the non-signified or non-disgraced beings around an individual affected by these issues) attribute negative characteristics to that person by virtue of their affliction (Gullslet et al., 2014). Stigma may in some settings become a powerful influencer on social positioning and impact upon the power and agency of certain individuals. In accordance with Goffman (1963:5-6), stigma is part of a wider, unconscious social categorisation process, informing a set of expectations and demands from individuals that fall under these categories about what kinds of behaviours, values, et cetera they are expected to have. This is what Goffman terms a "virtual social identity" which may be at odds with someone's "actual social identity" – the values, personality attributes, and/or occupations a person possesses in reality. These stigmas can take various forms, but if we interpret a particular attribute as negative, differentiating from other types of people, and in extremes as dangerous or "bad", this will cause us to interpret that individual as "tainted and discounted" rather than "whole", normal or otherwise (Goffman, 1963:5-7). It is important to clarify also before going on that reflection or recognition of 'difference' can encompass a broad spectrum – stigmatising and exclusionary behaviour or language can take extreme forms, such as racist violence against ethnic or sexual minorities at one extreme, poorly phrased or insensitive comments in a workplace setting at a different place on that spectrum. This thesis will not attempt to delve into a discussion *of* the spectrum of stigmatisation and/or discrimination and the types of reactions and emotions it can evoke, but it is important to clarify that these terms are used for theoretical framing or are used in the context which they were spoken by my own research participants.

Modern analyses of stigma specifically around mental health examine specifically the issue of stigma *within* the very services and systems designed to help individuals with mental health problems, as in Slade (2014:29). Slade discusses the overall process of stigma as having three key elements: Lack of or outdated knowledge (ignorance), prevailing attitudes about recovery that focus on the negative and/or clinical aspects of illness, and discrimination can all

contribute to various forms of stigma around mental illness and recovery, even within the areas of the health system specifically intended to help. (Thornicroft, 2005, in Slade, 2014:29). Stigma is intrinsically linked to outward actions of discrimination and the ensuing difficulties individuals who are 'singled out' or stigmatised experience within particular social fields, such as within the workplace. Discrimination, such as workplace discrimination against employees with disabilities are one element of stigma as a larger social construct (Slade, 2014:29). Slade (2014) uses Thornicroft's (2005) outline of the process of stigma as having three core elements: "ignorance, prejudice and discrimination"; in other words, issues about lack of correct knowledge, negative attitudes, and behavioural actions, respectively (Thornicroft, 2005, in Slade, 2014:29).

Goffman (1963) argued that that stigmatised attributes fall into three main categories: physical disabilities; tribal stigmas such as belonging to a particular race or religion; and what are perceived as character weakness or defectiveness, including mental illness, substance addiction, unemployment, imprisonment, among others (Goffman, 1963:5). The notion that mental illness is linked to a "flaw" in character or otherwise inability to function as others in everyday society is not a remnant of stigmatising attitudes of the past. Landheim et al. (2016) contend that language around those affected by addition and mental illness often suggests the 'problem' lies within the affected individual themselves, rather than in the use of a drug, for example: "He or she cracked/snapped"; "They should just pull themselves together" (Landheim et al., 2016:159-160). This type of attitude, which only serves to stigmatise the entirety of the individual further, is also connected to a broader suspicion or fear around mental illness and substance addiction: that those affected will have a "negative future", meaning others around them are likely to be wary of entering into relationships or friendships with them, or considering them for work opportunities, for example (Landheim et al., 2016:159-160). This is what Goffman describes as the belief that the stigmatised individual is "not quite human. On this assumption we exercise varieties of discrimination, through which we effectively, if often unthinkingly, reduce his life chances." (Goffman, 1963:7). The types of language given for example in the above quote from Landheim et al. (2016) also suggest personal responsibility is a part of the stigma's structure within the social order, that the individual is responsible for both the cause or nature of the issue they are stigmatised for having, and responsible again for "fixing" it.

In Thornberg's (2015) study of the stigma process in bullying amongst children, it is also shown that stigmatised individuals become "stuck" in the cycle of self-stigma and self-blame due to this, and efforts by the individual to change their identity, appearance or other features of themselves that they are judged for bear little fruit due to the overarching social structure and stigma's role within it (Thornberg, 2015:316-318). Gullslet, Kim & Borg (2014) found that individuals with mental health difficulties experienced both "self-labelling" and "labelling by others" as having a detrimental effect on social life and in various settings.

> Social injustice as a deprivation of access to social roles, and not being accepted in the community as a respected citizen can be a part of the problem, thereby sustaining the labelling and stigma. This represents a deprivation of the opportunity to be included in different levels or groups in society. (Gullslet et al., 2014)

Other researchers have also pointed to the reinforcement of stigma through negative media portrayals of individuals with mental illness which suggest these individuals are dangerous to the so-called "normal population" (Perese, 2007:285-286), in some cases leading to "NIMBY" movements in communities ("not in my backyard") that oppose residential solutions for individuals undergoing treatment for mental illness (Perese, 2007:286, and Lyngstad, 2000). Individuals affected by mental illness are, conversely, far more likely to be victims of crime, neglect in care services, or family violence (Perese, 2007:288-289). Significant numbers of individuals with mental illness experience unemployment and social isolation long after ending intensive treatment, and although most express a desire to work and be active, are restricted by societal stigma and by the passive nature of the "ill" role which presents barriers to becoming "active" in society through taking on other roles, such as in the workplace (Borg & Kristiansen, 2008:512-516).

Recovery and self-stigma

I will now discuss specifically self-stigma, understood theoretically as the result of social, external stigmas that then affect a change in the stigmatised individual's own identity and sense of self. They also argue that the detrimental effects of stigma on individuals are not only a result of external discrimination, but a result of the process of "internalisation of the public attitudes and beliefs by the stigmatised person", resulting amongst other things in shame and withdrawal from social life (Krajewski et al., 2013:1136). As in Thornberg's (2015) analysis of bullying in schoolchildren, stigma is the core of labelling, "meaning-making", and interactions between individuals whereby victims of bullying and overall stigma are

constructed in the social field as "odd, different, [or] deviant" and that these stigmatising labels or categorisations are used as justifications for bullying or another mistreatment (Thornberg, 2015:310-311). Thornberg lists many examples whereby perpetrators in bullying interactions justify their actions as being entirely normal, and indeed required, in order to make the "deviant" individual learn and become more "normal". Perhaps even more significantly, the behaviour of the overall groups in the studies Thornberg (2015) analyses changes in order to support the "collectively maintained and constructed stigma" (Goffman, 1963, in Thornberg, 2015). This meant that in many cases, even children not directly perpetrating in bullying interactions, believed that the stigma was justifiable, or feared "social contamination" from being associated with the stigmatised individual and indirectly contributed to the isolation of the victims through these types of attitudes and behaviours (Thornberg, 2015). A label is a definition, and when applied to a person, it identifies or defines what time or person he or she is. A label can be either 'deviant' or 'normal'. When individuals are labelled as deviant, they are defined as people who violate important social taken-for-granted norms of the social group, culture, or society (Phelan & Link, 1999, in Thornberg, 2015:311).

On culture and intercultural communication

The recovery college and the method of co-production can be interpreted as seeking to create an alternative organisational culture within existing hierarchical systems. Bang (2013:327) defines the development of cultural groups through the shared experience of meaningful problems; solving them as a group and observing the effect of said solutions; and the inclusion of new members into the group and the transference of said problem-solving methods to others. Cultural groups can develop in a variety of social systems, such as within organisational culture as articulated thus:

> …the house band or company football team, in departments, … in horizontal layers (for example amongst "the boys on the floor", amongst middle managers or amongst upper management) or in work groups and professions in organisations (for example amongst economics, jurists, nurses, teachers or sociologists. (Bang, 2013:329)

More broadly, culture is not only to be recognised in terms of definable ethnic or so-called traditional cultures, but is also reflected at in multiple layers of society, and is in a state of flux (Døving, 2009:12), in contrast to essentialist views of culture that view it as a stable, bordered construct of traditional values which leads to classification of individual identities as being culturally bound (Døving, 2009:12). There are cultures in the making *between* different

individuals in the workplace, at school, within social circles, within political life – in which different facets of culture interact and may also conflict with one another (Piller, 2017:85). For instance, internal organisational cultures will variably be affected by wider socio-political contexts (Stašys, Šimanskienė, & Paužuolienė, 2017). Such multidimensional processes are reflected for instance in concepts such as assimilation, integration, segregation and exclusion (Døving 2009:8-12).

Gullestad (2002) describes the Norwegian tendency towards the desire to categorise, as part of an "imagined sameness" between those who are Norwegian, making the "invisible fences" between those who are living in Norway, but "not quite Norwegian" clear in these types of social interactions (Gullestad, 2002:47). This may also be applied to individuals who find themselves outliers in Norwegian society despite having been born in Norway as it is to those living in but born outside of Norway, reflecting notions of socially prescribed norms and laws that make up "Norwegian sameness". This reflects the underlying and often unspoken concept that there is an 'in-group' that is made up of those who confirm to standards of societal, social and cultural norms; having a job, gaining an education, having a social network, being law-abiding, and so forth. In Bourdieu's (1977) framework, it is the economically and socially privileged who set the ideal trends and represent the 'in-group', they dictate the high standards of taste, comportment and lifestyle, et cetera. Society's many layers of complex social, political, economic and cultural norms and rules for comportment are often revealed by those who supposedly fall "outside" or do not conform to these, much more clearly than expressions of everyday conformity. This tension is directly related to marginalisation and stigma, as stigma overall is a social framework used to categorise those individuals, behaviours or traits which are considered deviant.

As will be touched upon in chapter four, discourses around segregation and assimilation mark much of the history of how those with mental illness have been governed and ushered into 'closed worlds' away from others (Goffman, 1961; Foucault 1964). Dalgard & Thapa (2007:9; cf. Bachke, 2017) argues that rather than being multicultural[5] in orientation and public policy, "…Norway is an assimilationist, rather than a pluralistic country." According to Døving, "a multiculturalist society has additionally self-awareness and politics that looks after its diversity" (Døving, 2009:7).

One example is that of subcultures formed in major cities in Norway, either in parks, shopping centres or railway stations can serve as examples, thus the types of social circles

formed by marginalised groups who are 'hanging out' in public places; often hotspots in the cities for drug use and which are formed among those living with substance dependence and/or mental health issues (Landheim et al., 2016). These environments are highlighted across municipal policies as areas of illegal activity and violence at the margins of society, and various attempts are made to split up these groups or confine them to specific areas. From the Norwegian majority position, these people may be in many respects 'outliers' or "out of place", which may be considered threatening to those on the 'inside', as in Douglas (1966:33-36). Patients suffering from complicated or difficult conditions such as comorbid substance dependence and mental health issues do not fit into the structural hierarchy of the health system (Pinxten & Lievens, 2014). Hence, it is critical for both the service users themselves and for society to develop adequate recovery measures.

As an example of these measures, the recovery college should consider offering their services to all municipal residents pursuing recovery, whether they are ethnically Norwegian or of other backgrounds. More broadly, there is a recognised need for intercultural communication skills due to the increasingly ethnically and culturally diverse nature of the service users within the health sector. Perspectives from anthropology can give insights not necessarily produced by reliance on evidence-based knowledge, for example with regards to differences in how illness is perceived, experienced and communicated about across cultures (Manson, 1997[6]; Leclerc-Madlala & Alobaidi, 2006, Verrept, 2012; Pimmer, Spikol, & Glocker, 2013). Incorporation of native cultural perspectives into development of new surveys about mental health and wellbeing had a significant effect on diagnosis and treatment within the community, so could be seen as an example of early co-production. As will be discussed in chapter eight, the college so far has been tailed to ethnic Norwegians. Verrept (2012) suggests that language barriers are a pressing barrier to ethnic minority service users receiving adequate care and follow-up, and that a lack of adequate or ad-hoc intercultural mediation efforts in addition to stereotyping and discrimination in an already stretched health system significantly affects health outcomes of linguistic and ethnic minorities.

Theories of culture and integration are also key to examining the broader concept of miscommunication and its effects, alternatively, stigmatisation and marginalisation through 'othering' when different competencies interact within a shared organizational space. For example, how is the term 'recovery' framed, analysed or interpreted, and the issues of renegotiating identity and reintegrating into the wider community can be reflected in language

choices. Choice of language and terminology used by the facilitators of the program can reflect power differences and dynamics, cultural and internal conflicts with communication, and experiential positionality (Jensen, 2006:10-12) in a variety of ways. Use of language within settings such as co-production meetings are telling as reflection of internal cultural dynamics, which will be explored later in the thesis. "Culture talk" in society can be used as a way of masking discriminatory or racist attitudes and excusing discriminatory behaviours, suggests Piller (2011, 129-136). Returning to the concept of habitus discussed earlier (Husu, 2013:266-267), cultural asymmetries and tensions between different parties can be reflected within the dynamics of communication and how they attempt to establish comfort and rapport with one another, especially in ritualised, formal or organisational situations (Ahlsén & Lindström, 2012).

In cognitive anthropology (D'Andrade 1984), culture is understood to constitute meaning systems that serve referential, constitutive, directive and evocative functions in the lives of human beings. In this view, culture consists of knowledge in terms of cultural categories and schemas but also constitutive rules that guide actions, and with built-in values and norms. Lakoff & Johnson (1980:189-187) demonstrate how terminology and use of metaphor can reflect deeper societal attitudes about morality and acceptable and unacceptable behaviours. Following the values and norms of the in-group are intrinsically rewarding, while breaking with societal expectations evoke negative feelings. Piller (2011:15-16), on the other hand, focuses on what counts as culture in which culture can be seen as an ideological construct called into play by social actors to produce and reproduce social categories and boundaries. Culture is not only defined through self-expression or "possession of traits" but in relation to identity: culture as "asset" (often as in art); as "challenge", encompassing aspects of social life and various types of 'unwritten rules' and codes (D'Andrade's constitutive rules) such as tipping and dress codes; institutions such as "citizenship" – "consisting of practices that are widely seen as signifying a particular identity". Cultural spaces can be in some cases easily identified with because of factors that include certain types of individual identities and definitions and exclude others, argues Piller (2011, 15-16), which is perhaps reflected in movements such as "Mad Pride" that challenge or try to "reclaim" stigmatising connotations around mental illness (Slade, 2014:30).

Chapter three: Methodology

Introduction

This chapter will explain the methods used for this thesis, methodological justifications for these, discuss the fieldwork process and challenges or unexpected events, and finally ethical considerations of the overall study. I will reflect upon the research questions, my motivations for undertaking this research and also upon my own role as researcher in a variety of settings. I will present my research field and the overall implications of undertaking such a study. This chapter will also briefly outline the parameters of the subject of my study, i.e. the Bugard recovery college project, and the positioning of participants.

Access to the field and role as researcher

When presenting my research interests and discussing potential project ideas with my supervisor, she informed me that she knew of a project newly beginning in the municipality of Bugard, namely the establishment of a recovery college. She put me in contact with key individuals on the project board. I first met with my contact at the recovery college in late February 2018. From there onwards I followed the development of the project during the distinct phases of its becoming. These I will briefly sum up for the sake of clarity:

1. From late spring 2018 and onwards, I attended planning/organisational meetings during the intense planning stage. Here I was strictly observing the meetings, taking notes and recording but also socializing in the breaks.

2. A more *inclusive project group* was formed in March 2018, mainly composed of service users, experience consultants and a few health professionals. Here I was invited to partake as a participant observer at meeting throughout the year of my study.

3. I attended two shared-competence building courses as a course participant: a three-day course on health pedagogy and a course in setting up a recovery college facilitated by representatives from Nottingham Recovery College. Health pedagogy is understood as the use of pedagogic tools to assist persons that have lasting health challenges and their families to increase their understanding of their own situation, and become stronger through mastering living with such challenges (Vågan, 2013, translation mine), and was a key concept for the recovery college, who were interested in competence-building for teachers and planners via this course.

4. Ultimately, the curriculum and course content were to be produced by small *coproducing groups*. Invited to join one of these, I was fully emerged in the ongoing tasks, together with informants, coproducing a course and its content. My fieldwork ended after attending the summing-up project group meeting after two courses had been delivered in 2019.

Reflections on fieldwork roles and access

My fieldwork roles moved from strictly observing and recording to participant observation and ultimately participatory research action: During the initial months of fieldwork – in the planning stage of the recovery college project - I was given permission to attend all the board meetings, requested by the municipality to take visual and audio recordings and notes where those participating in the meeting gave their consent on those occasions (as well as receiving the minutes from each meeting), to inform my analysis of how the project had been developed from the beginning stages through to the ultimate establishment of the project (first semester's worth of classes). I was not only given permission to undertake visual and audio recording in observational settings (board meetings) but actually requested explicitly to do so by my field contacts: They expressed that it was important to them and to me to gain physical evidence of co-production taking place within this new project. I was quite privileged in that my access to the field has been for the most part unproblematic and unchallenged. This is mainly due to preestablished rapport between my supervisor and key contacts I was given access to, and then having these key contacts promote 'my cause' as it were, assisting in the process of data collection by justifying my role at meetings and other events. Having an official contact introduce my research and justify its value to the recovery college's development to the other project group members in the initial stages of fieldwork undoubtably provided me with a warmer welcome and easier start than I would perhaps have achieved alone. This enabled me to be relatively free in my methodological choices.

For the most part, I received very little resistance, at least addressed to me personally, about the use of observation, interviews and action research for this study. In some of the very first meetings, I sensed some doubt from some municipal officials about my capacity to communicate/understand in Norwegian (as I had introduced myself in English, but also been introduced by a source within the municipality in Norwegian). I was lucky in these situations that my sources within the municipality that originally provided me with access to the field were very positive towards my work and also encouraged the acceptance of my work by others.

They had the power in that situation that I as researcher, observer, foreign student from a different institution, did not: the authority to express why the research on this topic was crucial and why *they* in the municipality believed it was important for them; thereby welcoming me as equally important as the other members of the board. After some time (and after improving my Norwegian skills through the process of working on this project and others), I was more welcome within this “inner circle” and the more permanent members usually greeted me as warmly as they did the others when they saw me at meetings. The overall rapport established was greatly beneficial in providing opportunities for and easing the process of facilitating the other types of research used in my fieldwork, in line with Musantee & Gravlee’s (2014) definition of rapport as “when members of the researched community and the researcher come to the point when each is committed to help the other achieve his or her goals” (Musantee & Gravlee, 2014:275).

Methodology

This is a qualitative research that utilises a variety of methods within the frame of a case study methodology, including here participant observation and interviews and during the ultimate months of fieldwork; participatory action research. Hence, while operating basically within a constructivist research paradigm, I also utilize a transformative perspective (Creswell & Cresswell 2018:8-10). The case study method necessitates clear parameters such as period of time, location or individuals involved in specific cases, settings, and are generally current, in that they occur concurrently with the research, rather than a long way back in time (Creswell & Poth, 2017:97-98). Specifically, the parameters for this study were, with regards to time and activity: the development process (organisation and co-production meetings and organised courses for competence building) of the recovery college between the early stages and first ‘idea collection’ event in March 2018, and the last meeting before summer, after the first semester of courses had been completed in June 2019. Most of the field settings contained the same pool of participants, with an ‘inner circle’ of key and most frequent participants and an ‘outer circle’ of those who participated in some co-production settings.

In interviews I took, many participants refer to past events in relation to this process and relate to ‘then’ and ‘now’ of the recovery movement in Bugard. These insights are valuable with regards to the context of the case study and also examining how changes in health and social services have led to the successful implementation of a project such as the recovery college. The field settings also occurred in a variety of physical locations. Certain events, such as competence-building events involving international speakers, were much larger than

meetings concerned more with logistics and planning. In this way the case study becomes somewhat an 'extended' case or "non-bounded ethnographic site" as in Teig (2012:56), rather than existing in a physically bounded location. The field site was changing, and ethnographic descriptions of smaller case examples discuss the particulars of that ethnographic site, the types of settings that were most common, and how these may impact the dynamic of the participants.

The intrinsic case study method (Creswell & Poth, 2017:99) is likely the most apt descriptor here, in that the case presented (the development of the Bugard recovery college) is a relatively unusual situation, and requires a detailed outline and descriptions of the parameter of the case and the field of study, in order to create the 'narrative' of the college's development and the issues and interactions occurring along the way. Multiple smaller cases are presented during the thesis by way of both ethnographic description and case study analysis, such as one informant's experiences of stigma as an experience consultant in chapter eight, that make up the larger case of the recovery college. These are used to shed light upon and discuss different facets of the larger central case. As I have discussed, the field of study itself represents a multidisciplinary and complex setting, even in the 'day-to-day life' of bureaucratic meetings or networking events, thus the field was best approached by using a variety of methods.

Constructivist research often analyses the interactions between individuals and seeks to consider cultural norms and other contextual factors that impact the meaning creation of informants, contending that the way individuals make sense of their world and their communications with others is influenced by these cultural and historical factors (Creswell & Creswell, 2018:8). Key features of this type of research are open-ending questioning and the generation of meaning via the interaction with participants (Creswell & Creswell, 2018:7-8). A transformative perspective suggests that research should focus on fighting oppression, must also have a political and action-based research agenda against oppression, for example by assisting in institutional change, and by focusing on specific issues regarding social injustices such as inequality and empowerment (Creswell & Creswell, 2018:9-10). Creswell & Creswell (2018:9-10) argue that transformative research should also be conducted collaboratively, and involve the participants where possible, seek to bring forward marginalised or oppressed voices and otherwise ensure that they are not further marginalised by the research process. Another way of describing this type of research approach, as I have done otherwise in this chapter, active or advocacy research, as in Trotter & Schensul (1998:693). Action research on cultural interactions and settings should, according to Trotter & Schensul (1998:693), engage with a

variety of factors that can influence social inequalities and asymmetries between individuals, as well as recognise the structural nature of these factors, such as class and power. This research study is to some degree participatory action research (Trotter & Schensul, 1998:693) in that during the process I was a member of a co-production group, assisted in producing course materials which were then utilised by the Bugard recovery college, and gave insights in certain settings which may have impacted the overall end 'product' of the college, however I would hesitate to use this term over action or advocacy research as I was not in a sense in a long-term partnership for the purposes of the college (I was first and foremost a researcher, not primarily a producer), however action research describes the process of joining a co-production group and other field settings I was involved in well. I also believe that issues I discuss in this thesis, such as stigma and marginalisation of individuals with mental health and/or substance use issues, and the ongoing difficulties faced by some individuals with lived experience of these in co-production settings, relate to larger societal issues of stigma and "oppression", and I hope that my research contributes to the ongoing discussion around these issues, as well as perhaps providing insights into how organisational settings can be impact by larger issues of social injustice. This study is also phenomenological in that it in some ways describes common meanings for a group of individuals of *their* experience of a concept/phenomenon, and looks to compare and find commonalities within the participants' experiences of said phenomena (Creswell: 2017:75-77). In this study, such concepts were primarily the experience of co-production, the viewing or rating of different competencies and the experience of having different competencies within organisational settings, the experience of stigma, and openness to cultural inclusion/desire to adopt intercultural perspectives.

This study is ethnographic in nature in that it involves the reviewing of shared patterns of behaviour, language and actions of a culture-sharing group over a prolonged period of time (Creswell & Poth, 2017:91). Ethnography is a both a qualitative research approach and a final research product, and most often examines participants of the culture-sharing group through observation, in which the researcher is immersed in daily life activities of their participants, observes and interviews them, analysing behaviour, language and the ways in which the participants interact with each other (Creswell & Poth, 2017:91). However, it is not a wholly ethnographic or ethnographically dominant study as described in Madden (2010:78-80), I was in a sense 'removed' from my subjects. I was not involved in ethnographically documenting their daily or personal lives, nor were these individuals' lives and experiences overall the key focus of this study. The field settings I collected my data in were also not a part of their

everyday, but of their work lives, and indeed the settings I utilised ethnographic methods in (namely participant observation but also formal/informal interviewing) made up a very small and specific part of my participants' working lives. Part of what makes the field interesting in this way is the created, *artificial* nature of the organisational setting. With these considerations in mind, I chose ultimately to develop a case study, defined as following:

> an in-depth analysis of a case, often a program, event, activity, process, or one or more individuals… bounded by time and activity, and researchers collect detailed information using a variety of data collection procedures of a sustained period of time (Stake, 1995; Yin, 2009, 2012, 2014; in Creswell & Creswell, 2018:14).

Choice of data collection methods

I undertook six personal, semi-structured in-depth interviews with individuals directly involved in the recovery college group and the co-production process, a number of informal interviews with various participants across the course of my fieldwork, participant observation during a variety of settings: meetings for organisational and planning tasks, meetings for co-production, and workshop groups, courses run by external organisations and larger networking events run for the purpose of spreading information about the recovery college and seeking inspiration for future courses; and participatory action research, whereby I made a conscious choice to participate in group work during a week-long course on building a recovery college, with participants from both Nottingham Recovery College and Bugard recovery college, and as an active member of co-production for a specific course that is now part of the Bugard recovery college's syllabus. Part of this participatory action research involved assisting in the production of course materials and content. One such tool was an adaptation of Nottingham's "Wellbeing Toolbox", which I translated into Norwegian and modified after consultations during co-production meetings. (This document cannot be included in the Appendices owing to copyright issues). I also sought to undertake small-scale data analysis of anonymised feedback sheets designed by Bugard recovery college organisers to assess students' responses to the pilot run, this can be found in Appendix 1. I also 'mapped' events at which I was an observer, by recording who participated, the balance between competence by profession and/or experience at events such as meetings, the types of notifications I received about these events, and in what types of settings (time, location, and so forth) they were held (withheld due to anonymity concerns). The combination and diversity of methods allowed me to become suitably immersed in the ethnographic conditions of the study during observation and especially times of action

research, while maintaining an analytical distance during interviewing and focus group settings.

On interviews

I undertook six personal semi-structured life-world interviews, in order to gain insights into participants' interpretations and experiences of the phenomena I was examining, as in Kvale (2007:10-11). All these interviews were one-on-one private conversations in Norwegian, during which I took some notes, recorded and transcribed and translated into English afterwards before analysis. These interviews were for the most part deep interviews, containing warm-up questions around organisational or work tasks and roles, the development of recovery-oriented services in Bugard, their role in the recovery college project, among other things; reflection questions, seeking deeper descriptive information around certain themes such as intercultural communication, recovery and experience-based competence, and finally "rounding off questions" in order to not end abruptly on one of these "deeper points", in keeping with the model described in Tjora (2012:112-113).

All interviewees gave written and verbal consent to recording and notetaking, which the exception of one participant who wished specifically not to be recorded. In this case I relied solely on notetaking. For approximately half of my interviews, I had specific key individuals in mind I would like to interview, based on the interactions we had had previously and the degree to which I sensed they felt able to interact with me comfortably, their level of involvement with the college, and where specifically they were placed in terms of involvement and competence (i.e. regular role, and role within the college group, what types of competence they themselves had expressed as having). For the other half, I submitted a query openly to a wider group of key individuals that I had also interacted with previously, and took interviews with those who responded. Overall, I interviewed slightly more participants with competence from lived experience than those without, and some of informants had competence in a variety of areas, meaning they would necessarily define themselves as having one type or another competence. It was important to me to lean towards having a higher percentage of individuals with lived experience in my study as a recognition of the importance of the user voice and that these individuals need in general to work harder to have their competence recognised (Klevan et al., 2018:41), as was reflected in both theoretical and empirical findings of my research, so this was a conscious decision rather than aiming for a perfectly equal 'balance'. Although not something I originally set out to do, the 'varied' and 'mixed' nature of some of the participants' competence became clearer with further interviews, highlighting the 'spectrum' of lived

experience as discussed in Klevan et al. (2018:62-63) The aim of the interview guide for the personal interview was to ensure that that some specific themes were able to be discussed, while simultaneously allowing room for participants to reflect upon the different themes in their own way and bring up concepts that they felt were important. They were also given the opportunity towards the end of the formal interview to raise concerns or other themes that they saw as significant.

After completing each formal recorded interview, I transcribed immediately into Norwegian, and then translated into English the transcription. I then printed both versions and read through them while listening to the recordings, in order to perform a close textual analysis. I made many notes during this process regarding tone, inflection, and word choice of the participants, and compared these with notes I took during the initial interview while the participants were speaking. In addition to these more structured interviews, I undertook twenty informal interviews with a variety of participants within the recovery college group throughout my fieldwork – ranging from short and casual conversations about interesting themes during breaks, to longer, more complex narratives during co-production meetings, for example. These I did not record, but noted down as much as I could, generally just after the informal interview had taken place, in my field diary along with notes on context, tone, and topic.

On participant observation

My fieldwork officially starting with observation at the "brainstorming" or idea collection event held in March 2018, facilitated by the then-central board members and attended by the project group composed of a majority of service user or caregivers. I began my field diary here, recorded some official speeches and one focus group which I was not involved in but did observe with the participants' consent. With this as my starting point, I was throughout the course of my fieldwork present at twelve planning meetings. Most of these meetings lasted around 2-3 hours and were held at one of the official municipal locations. Overall, not including my own co-production experiences, I was attendant as observer at twenty meetings or otherwise related events, many of which lasted entire days. I was also given access to the minutes of all the (usually shorter, but not always) meetings afterwards, as well as oversight over who was invited. With verbal consent given by those present at each meeting, I was given permission to record (either with sound or video, or both) and take field notes while observing. At most meetings, I took only the observation role, however at some of the later meetings this changed. I was asked to give an opinion on certain things, and to take minutes, having been well acquainted with most of the regular meeting participants by this point. This designated a

shift from observation to participant observation to participatory action research as primary methods in these settings. Oversight over all meetings and other scheduled events such as courses, as well as supplementary materials from course development can be found in the appendix. Observing at length in this manner, recording and maintaining a field diary of these settings provided key insights and shaped a great deal of the empirical makeup of the overall case study. The types of questions I asked in my interviews were formed a great deal by the types of interactions and occurrences I observed on these occasions. The overall rapport established during these settings assisted in opening up further field opportunities, such as that of undertaking action research, as detailed in the next section of the chapter, and I believe established a sense of familiarity between my participants and myself as researcher. My presence at meetings appeared to help my participants be comfortable with me when we undertook our interviews, as well as providing opportunities for informal interviews. It also positioned my research as something of interest and importance for them as stakeholders in the case study environment and showed my genuine interest in their cause' as well as the relevance of my own, allowing again for the opening of action research opportunities later on. Additionally, observing was vital for examining subtler, inexplicit dynamics in the interactions between my participants, data that could not be obtained simply through direct or indirect interviewing. Although in most cases, the participants did not appear to 'forget' they were being observed, in some cases, seemingly off-hand or off-topic comments were made in this vein, that provided interesting insights not revealed in interviews.

Moving towards action research

In addition to observation on the aforementioned occasions, I took part in action research, taking on a role as a core member of the researched group, as defined in Musantee & Gravlee (2014:271-272), firstly during a four-day course led by two representatives (one the main coordinator of the college, and the other a peer trainer who used their own experience as part of their teaching) Nottingham Recovery College, of which the majority of the recovery college group locally attended. This research was categorized by actively taking part in discussions and groupwork in the same manner as all others attending. We (myself, my supervisor and our municipal contact) deemed that the setting and duration of the program would be inappropriate for observation, and that it would be mutually beneficial for us and the group at large for everyone to work together. This turned out to be the right decision. It also allowed me to become much better acquainted with some members of the recovery group, which was a positive development. I was as a result invited to the newly reformed development group for

one of the courses, which had fallen behind the other groups. This was also, luckily, the course I had hoped to follow to completion and focus on. During these four days, my thesis supervisor was also present. Participating in this Nottingham-led course led me thereby to the second part of my action research role, as part of the development team (I was acting as a 'educated professional (*fagperson*)' with regards to the question of group competence). I spent around sixty hours in action research here, mostly in meetings, but also assisting with development work, such as translation of relevant documents from Nottingham's resources that they made available to the recovery college into Norwegian, research, and developing lecture slides and assignments for course participants. Participating in this way allowed me to undertake action/advocacy research, for the motivations discussed earlier in this chapter, but also, crucially, to examine particular areas of interest and the dynamics of the co-production setting and development settings firsthand, rather than through the perspectives relayed in observational settings or in interviews.

Ethical concerns: sensitive topics and potential conflicts of interest

This study was approved by NSD (The Norwegian Institute for data research) before undertaking fieldwork, and I have made all efforts to ensure that this study is ethically sound, and where there is a potential risk of ethical concerns considered at length the risk to participants versus potential benefits to the wider community (Kvale & Brinkmann, 2015, 107). Preventing the release of potentially identifying information of a sensitive nature is an ethical problem for many researchers, but in this case the small and localised participant pool also makes for a fraught situation. Overall, dealing with potentially vulnerable people and the disclosure/discussion of potentially emotionally traumatic subjects related to substance dependence/mental illness recovery provides a series of ethical considerations and reasons to be very cautious about not just how the data is handled, but also how the data is developed and produced so as not to cause any further harm to people who are attempting to move forward from difficult situations. Norwegian research ethics law state that in the social sciences, the issue of psychological harm should be properly considered and applies to "everyday discomfort, risk of traumatisation and also more serious mental strain which the research may cause the participants." (NESH, 2016:19). Although this thesis deals with serious issues from both a theoretical and empirical perspective, I was very careful to ensure that the structure and wording used in the interview guides does not specifically ask for *any* details of lived experience that individuals may have had. I will also stress that were I have been privileged to receive personal and/or sensitive histories from my informants in any fieldwork settings, these

have been volunteered completely by the individuals themselves without any kind of prompting or encouragement from my side. In any case, this is not a thesis about individual recovery journeys, nor does it seek to dwell on the difficulties of mental illness or substance dependence, and where snippets of these are included, they are done so with both careful consideration of the context they were introduced in within the field and their relevance to the overall study.

All data collection work, including action research and course development work, was voluntary and unpaid. All participants and informants, including co-developers, were fully informed of my role as researcher and that data collected would be potentially used in this masters' thesis.

Ethical concerns: deidentification

This project and the methods of data collection used were approved beforehand by the Norwegian institute for research data (NSD). The risk of indirect identification of participants was made clear during this process, namely due to the slight risk that individuals can be identified due to working within the departments named in the study. I have therefore given the municipality a fictive name. Additionally, the risk of identification becomes even more pertinent when considering that many participants in the recovery college group and potential informants for the study have experienced mental health and/or substance use challenges.

In accordance with NESH (2016) "when a researcher observes groups and communities, it can be difficult to protect the privacy of individuals who have not given consent directly, or who have actively declined, but who nevertheless remain in the situation." (NESH 2016:19). Although at every meeting and/or event, those attended were informed of my presence, purposes and intentions of my role as researcher and data collection and asked for their consent, it may be the case that some individuals in certain group situations were less sure of or less aware of my role, although I did not receive any active full declinations at any point. I could put into different forms of data collection, however also compounded the difficulty of considering the ethics of how much identifying detail could be included, when thinking about the likelihood of my informants actually being able to gain access to and read my work, and potentially identify colleagues within it, for example. I have chosen to deidentify completely: no identifying details about location, specific municipalities, organisations or departments. However, this has proved nonetheless difficult due to the fact that there are few recovery college projects in Norway today. This made it extra crucial to anonymise participants. Therefore, where empirical examples are used, I have used only an initial with no description

of the person in question, and in which the initial is not in any way linked to their real name; I have tried not to identified anyone directly with a job title or job location, such as department, only described the type of competence they work with and in certain cases mentioned a field such as health or social work where this has been relevant to the data, or a broad descriptor such as "involved with activity centres" which covers hundreds of potential types of employment within this field. I have reassigned genders to some individuals, as well as asserting some data components under more than one individual initial, in order that a reader should not be able to form an idea of informant K (to give a hypothetical example) that may in any way lead to possible identification.

This study situates itself within a complex field, in itself containing many possibilities and pathways, which made narrowing the focus of the thesis and assembling data a difficult task. Although concessions to deidentification and possible modification of how sensitive topics were presented needed to be made in order to ensure the safety of my informants, I have done my best to not skew the revelations made in any direction and allow the data to speak for itself, rather doing my best to be dynamic in my role as researcher and letting the questions and concerns of the thesis also evolve where necessary over the progression of fieldwork.

Through utilising different methods and being privy to a wide number of ethnographic settings I tried at all times to be aware of my "place from which the observer observes" and the unavoidable impact of outside observation of my presence and my own individual predispositions and other characteristics on the field and the data (Musantee & Gravlee, 2014:280-281). Positive rapport as previously mentioned, helped somewhat after a time, as I felt over time the majority of participants had seen me or interacted with me in some way and felt more relaxed about my presence, hopefully allowing them to act more 'organically' and in at least a closer approximation to how they would have if I was not there. The process of rapport building and then participating (moving from observant to participant) in action research in itself raises ethical quandaries. In the role of action researcher, as a member of the co-production group for one of the courses and as an active participant in Nottingham Recovery College's "College in a box" course, I was privy to more conversations, both casual during breaks and in the official co-production capacity, and incidentally found out much more about my informants' personal lives and experiences that I may not have otherwise. While those involved were all made aware that I was using our co-production meetings in that setting as part of my research, and asked about it repeatedly, I can see that this is a situation where the

borders around researcher and participant began to merge. An example that comes to mind is when I was asked by a member of my co-production team asked me if I would be attending the follow-up course in health pedagogy and thereby intended to become a teacher at the recovery college. I replied by saying I did not think I would be able to take on a teacher role, as I was not municipally employed, and that I needed to focus on finishing my degree (at that time, there was little to no discussion of paid positions for teachers not already municipally employed). Another member of the group in that moment also expressed surprise that I was not employed municipally, saying she thought I "worked in a health department somewhere". I explained that all the work I was doing, was in fact voluntary and a part of my thesis, and that I relied on my own funding to get through my degree. Both were then understanding and expressed that they thought this was positive, but I particularly recall the intrigue on the first questioner's face when I mentioned my paid job and the demands of my thesis –as though she maybe had forgotten that although I also wanted to see the recovery college succeed, I had my own personal motivations and demands placed on me that were quite removed from the college project. All these situations – the awkwardness of sitting in meetings with limited language skills and feeling one or two sceptical gazes in the beginning of fieldwork to the casual and warm conversation nearing the end of the fieldwork process when I had to express that I would not be continuing with the project in the same capacity, or where I participated in a conversation during co-production which then turned to one group member's personal and family life, represent different expressions of the "participant-observer continuum", where it is important to find the right balance for the situation at hand and also make explicit in analysis where the researcher is placed between those roles in that situation (Musantee & Gravlee, 2014:270-272). Musantee & Gravlee (2014:271) also argue that the roles of participant, observer and action researcher are dynamic and fluid in the research setting, with the identities of both researcher and researched party shifting throughout the duration of fieldwork, as I felt during these occasions and others.

Language and translation

The recovery college used as the main case study in this thesis is innovative within Norway, and much of the prior research on this specific type of recovery college and the models used by the researched party are English. Also, much of the surrounding research into the concepts and issues of reintegration and recovery that I am using comes from Norwegian sources, written into my own, native English speaker's voice, into a thesis that may again be translated back into Norwegian. Translation proved a troublesome issue at certain stages of fieldwork – I saw

firsthand some of the issues arising from trying to translate the terms and concepts used in the British-designed material into a Norwegian context, for example, and was also concerned with how to avoid these types of problems when translating 'back' to English. The difficulty with translation is that a term does not simply translate by translating *literally*, it needs to translate culturally and provide meaning for someone in their "thinking" language or "innate" language, their inner 'cultural code' (Benton & Craib, 2011:97-99). Similarities can always be drawn, and the differences in interpretations of these issues in different cultures can ultimately lead to a more significant understanding when compared and analysed together (Benton & Craib, 2011:97-99).

Although my spoken Norwegian skills were less than perfect at the beginning of this master's program, I had after a time sufficient skill to undertake my field activities in Norwegian although the master was always planned to be in English. Due to my language skills being more in development than seasoned second language speakers throughout my fieldwork, I provided in some cases (anonymised) examples to my supervisor for clarification on nuances, slang or regional terms. I have also pointed throughout the text to occasions where translation between Norwegian and English does not satisfactorily cover the original term (i.e. there isn't an appropriate direct translation). I have also thoroughly analysed my field data, such as transcribed interviews, in both the original Norwegian and my English translations in order to clarify areas where I felt I potentially did not grasp the entirety of what that informant meant (for example). As Madden (2010:63-64) describes, navigating ethnographic situations in a second language that one is familiar with but clearly not one's own can be difficult, especially when one is nervous about the new situation, anxious to build rapport or "fit in". I was conscious to use concise and accessible terminology in my interview guides while addressing the subject matter; and had help in reviewing the final translations (to Norwegian) by my supervisor, while ensuring that overly technical or stylised language choices would not speak overly to my non-native status. By the end of fieldwork my Norwegian skills had improved, and I was able to work with the data in the original transcriptions. I have carefully considered how they are translated in order to communicate the meaning from one language to another. Where exact translations for words are unavailable or complicated, I have made this clear.

Secondary sources and Internet

Data gathered during personal and focus group interviews and ethnographic observation are the primary sources for writing this master thesis. Secondary sources are used as well, such

as academic texts and examples from the media. I have also drawn on a range of white papers, statistics and policy documents directly from Norwegian health and social authorities. I have used sources in both English and Norwegian.

Chapter four: structure, context and hierarchy

Introduction

The Bugard recovery college posits itself as a radical 'new way' stemming from several years of ongoing change within the local, regional and overall Norwegian health and social systems. I will outline some characteristics of the social field and structure within which the recovery college project evolves, which is the mental health and substance use services at municipal and state level in Norway, and the changes that have occurred in this sector in recent years with, among other things, the development of recovery-focused services within the area. After reflecting on empirical material presented, I will provide a brief outline and historical background for these services and sort out some basic divisions of labour between municipal services and the specialist health services and certain private initiatives with which the municipality cooperates.

The dynamics of the bureaucratic meeting

As part of my fieldwork, I had the opportunity to follow those involved from the relative start of the project, and a key part of what I observed were planning meetings, as outlined in the Method chapter. These meetings served a variety of functions for the college which I identified in the main as: logistical planning, such as budgetary concerns and finding of staff or switching around of individual roles for those involved in the college, finding locations for the eventual college; co-production, whereby those involved would plan or discuss the courses in development, including eventual approval of the courses; and addressing of issues, concerns and conflicts, often related to how much time was being devoted to one particular aspect of a course or how much time an individual had been devoting to the development of the college in addition to regular work tasks. Overall, these meetings and those present was a key factor in the development of the project throughout the year.

While the regular 'board' itself remained more or less the same, with some that quit or were reassigned over the year plus that the project was in development, there were also many working on the project in various capacities who attended some, but not all, meetings. They were often employees of other departments with competence by experience who were asked to attend, and then asked their opinion on certain topics. Attendance overall varied, with some meetings having around ten to fifteen attendees, others only four or five. The following ethnographic excerpt is an example of what would be likely classed as a 'normal' meeting, where an average number of people were attending and where some decisions were made as to

the college. The description attempts to sketch an image of what attending one of these bureaucratic, ritualised settings was like:

> *The meeting location is almost as central as can be, with older, stone and wooden Norwegian buildings looming out of the cobblestones, boutiques, statues and pillars framing entranceways with cafés, fast food outlets and construction scaffolding greeting me as I turn the corner. The glass doors on one of the tallest and most impressive looking buildings greet me with the municipal emblem. At first, request into the microphone brooks an unintelligible response, and the person on the receiving end doesn't seem to be someone I met at any previous meeting. Suddenly one of the participants (an 'expert by experience') in my study, greets me jovially from behind. He knows the magic word to say into the speaker, and we gain access. Bypassing the spiralling marble stairs to the left, we make our way into the lift, where he asks me how the project is going. Before we can converse for long, the lift spoons us onto the correct floor. A glass door, framed in white, emblazoned with the emblem and department name lends the only clue to our location amongst the blank white walls, and here again must we be buzzed in. Inside, the central hallway quickly leads into a maze of white walls and doors without much in the way of defining markers to the outside eye. Ushered down another hallway, we come to an unmarked white door. Inside, a long white conference table, white walls, a white pull-down screen on the back wall, which one board member appears to be trying to get a presentation to appear on, frowning into his laptop. The centre of the white table contains a number of white coffee cups, steel coffee jugs, bowls of nuts, plates of fruit and biscuits. I greet the few employees already in the room, the organiser of the meeting (an 'expert by education') is hurrying around, commenting to the room about needing to start, about one who is not coming, about one is running late, and looking around the articles she has gathered at the head of the table, whereas the participant who I met on the way in is already looking at something on his phone. As I am setting up my camera and sound recorder, I see another meeting participant (an 'expert by education') come in, removing layers of outer clothing, and commenting matter-of-factly that he had trouble parking his bicycle outside, due to "a man peeing on the pavement outside, and I had to wait for him to move, because otherwise I couldn't get into the space to leave my bike." The organiser of the meeting, who has gone to fetch something, reappears again, and declares we should begin the meeting, despite missing one or two parties. It is determined that present at the meeting*

is one participant with competence by experience, with another who is meant to be arriving for the second half of the meeting. The rest of the participants are experts by education. Our organiser begins reading through an agenda after it becomes available on the screen. The first hour is dedicated to much discussion around logistics, the upcoming visit from representatives from Nottingham, and the planning of one of the courses which appears to be lagging behind. A discussion about certain principles within the course, between two experts by education, one the key organiser, takes around ten to fifteen minutes, before one of them receives a call from another department and leaves the room briefly. They soon return, mentioning that it was another 'expert by education' talking about an upcoming meeting with some local politicians, at which the fylkesmann *would also attend. After the first hour, we take a short break, wherein arrives another representative from the development groups, with competence by experience. Towards the end of the second hour, one 'expert by education' leaves early, stating she has a meeting with another department scheduled. After some more discussion on the potential name and logo for the project, and potential extra help for the development group that is lagging behind, the organiser begins to search for the dates for the next meeting, checking her calendar and offering potential dates to those still present. It is difficult at first to find a date, as we now are approaching a period of holidays, and some of those present state when they have booked their vacations for. A date is agreed on, the minutes are agreed to be sent to the organiser, and the meeting closes with several farewells, while some stay behind to discuss specific issues the meeting's organiser.*

The participants at meetings such as this one, were differently positioned within the overall order of the municipal and specialist health systems. Within this system of relationships and practices, municipal employees also often functioned as the factual leaders of the meeting. In the municipal order, they are at once reporting to and acting on behalf of the politicians, whom within the representative democratic system of the municipality are sanctioning the overall health plans for the municipality, the related expenditures, and who delegate decision-making in the area of the health services. The politicians themselves report to the Norwegian state's representative in the county (*fylkesmannen*). The leaders of the decentralized municipal health service providing units again report back to these bureaucratic officials in the department and act on their behalf with regards to overall policies and strategies. The decentralized mental health and substance dependence units have their own hierarchical order of departments.

Although the role of service users within these departments has changed substantially over the years with respect to self-determination and user decisions vis-à-vis service providers, they nonetheless are defined as in need of services at the receiving, lower end of the hierarchy. Hence, at a typical meeting like the one described above, one could find seated around the same table highly educated representatives from the upper echelons of municipal bureaucracy and the upper levels of the service-providing units, together with health personnel from municipal units, health personnel from the specialist health services, such as doctors, nurses and psychologists (not part of the municipal complex, but related, as is detailed further in the chapter, and a part of the overall group involved in the recovery college project), and 'experts by experience' or experience consultants employed in both the municipal and health services, and representatives of service users and caregivers.

The parties involved at different levels in the recovery college project are differently positioned within this overall system in everyday life, for example in terms of caregivers and care receivers, or as doctors versus psychologists versus nurses versus other health employees (such as those employed owing to their experience versus those employed owing to their education). In the context of the recovery college project, however, the participants are all supposed to exert and possess equal influence and power in coproducing the recovery college, regardless of otherwise position, educational background, social capital, workplace and so forth. We may argue that co-production within the recovery college seeks to so to say 'bracket off' an otherwise hierarchical order of things which under the everyday circumstances of work operates as such. For instance, the meeting participants have knowledge of each other in terms of educational and other forms of competencies, which are differently valued, which again affect their experience of own capital, their position in the system and their authority to make decisions, influence others, exercise power, and so forth. Asymmetries are inherent to the structural hierarchies outside of the unique co-production setting, and they seem also to partly translate into the co-production setting and who directs and heads the content of meetings. Cultural capital via education ('academic capital'), such as in the health area, bestows protected titles (Ringdal (2015), which again bestow authority to perform judgments, make decisions, perform treatments, or otherwise affect outcomes in various institutional settings – thereby bestowing power (Goetze, 2017:19). Position and office in bureaucratic settings recognise academic capital. Here presents the paradox: this is a field of asymmetrical positions and relationships that recognises education and protected titles as being of utmost importance. This

is the structure that the co-production setting, and the presence of competence by experience and experts by lived experience, by nature challenge.

The power invested in positions and in the actors occupying them by the system is made apparent in often subtle ways: the 'expert by education' who takes an important business call during a meeting and explains this via his involvement with local politicians, for example. Those who have the authority to lead discussions, raise new topics, make decisions, plan logistics: all the previously identified normal functions of a meeting were by and large determined by those who had the authority to make such decisions, an authority bestowed upon them outside of the 'equal space' of the meeting room and carried into it. According to Renedo & Marston 2015:490), the municipal space is "…both the 'medium' constraining social relations and social structure and an 'outcome' or manifestation of those social relations and social structure (see also Soja, 1989: 129). Structures speak via the authority or 'hidden power' vested in certain people by virtue of academic or other types of capital, as well as within inherent symbolic signs of power, such as in the imposing and detailed architecture in the building where the bureaucratic meetings were often held, as described previously. As Andersen (2013:56) argues, one who has defined, often hidden power can set the agenda, decide which topics are important and which to avoid, decide what is a problem and what is not, and decide which understanding of reality is most valid, and the service system as a whole largely defines what issues are relevant for the users of that service.

Historical antecedents

The Norwegian mental health system has undergone vast changes since the impact of decentralisation of the overall health sector and deinstitutionalisation of psychiatric services, and the impact of management reforms (Teig, 2012: 21-211/51-52). According to NAPHA, the broader development of mental health services in Norway follows the wider international trend, described as the following three stages: 1. Establishment of asylums to house those classified as mentally ill (1880-1955), 2. Deinstitutionalisation from the 1950s with more psychiatric treatments offered as outpatient services, which came to Norway slightly later in the 1970s (in Teig, 2012:51-52). This stage was also accompanied by a new array of psycho-pharma that came to revolutionize psychiatric treatments, with medication becoming the preferred option for treating mental illness (Slade, 2014:71-72). 3. Service reform from evidence-based perspectives and integration of locally based services with services offered at hospitals in later years, known as the "balanced care model" (NAPHA, 2015). Recovery in terms of the social, personal and holistic versus the purely clinical, as discussed in the theory chapter, has become

part of the agenda of the Norwegian state, along with promotion of agency, responsibility and inclusion of diverse perspectives[7]. This general movement from punishment and discipline towards care and agency posits the reality of the mental health system a long way from Goffman's famous "total institution" and isolated, "closed worlds" of psychiatric hospitals (Teig, 2012:51-52).

Prior to modern mental health policy, guidelines and establishment of specialist services, vulnerable individuals with mental illnesses in most Western countries were largely at the mercy of the psychiatric ideas of the time and subordinated by other dominant groups in society (Slade, 2014:69-71). Between 1750 and 1900 was the age in which mental disturbances or 'madness' came to be described as illnesses, requiring treatment. The primary focus of institutions, or asylums, for those categorised as mentally ill was to exclude those deemed a disturbance or problem away from majority society (Slade, 2014:69). According to Dalgard (2002:163), official tallying of individuals affected by mental illness began in Norway in 1824, initiated by religious authorities as a means to determine how many institutional places were required for treatment and housing. Institutional forms for treatment were disciplinary and corrective, rather than therapeutic (Hammerborg, 2016). These bureaucratic institutions gave more power to doctors and segregated away individuals deemed not fit for normal society, not only the mentally ill but also those in poverty (Teig, 2012:61). Even very early Norwegian surveys of admittances appear to point to a link between those who were diagnosed and committed for treatment, and those who had difficulties in employment or family life, alcohol abuse or were convicted of crimes (Dalgard, 2002:167).

Foucault (1977:199-201) argued that institutions such as psychiatric hospitals in the nineteenth century were constructed as to ensure a stable power relation and state of dominance, control and discipline, whereby those committed were always aware of their position and powerlessness through conditions of surveillance and removal of autonomy. Those were categorised in binary, dichotomous power relations: the "mad" and "abnormal" versus the "sane" and "normal" situation of those controlling the institution; both parties were aware of the hierarchy and dichotomy present, in this manner, compliance was assured (Foucault, 1977:199). For Foucault, exclusionary procedures were maintained by such institutions, and operated spatially within them, separating those in need of monitoring and treatment before being allowed (if they were allowed) to regain normal society, from the majority population (Peters and Besley, 2014:104-105). Goffman's (1961) famous "total

institution" model is characterised by bureaucratic and professional dominance in organisations he viewed as closed from the rest of society, whereby one organisation plans, controls and structures the daily lives, needs and interactions of those enclosed within.

Deinstitutionalisation and the 'building down' of these types of "total institutions" amidst criticisms around their organisation, structure and methods of control began in the 1970s in Norway, as part of restructuring of the overall mental health services and replacement of long-term facilities with outpatient clinics and other methods of treatment within communities (Teig, 2012:67-68). Certain scholars have disapproved of Goffman's (1961) model as depicting such institutions in an overly negative light (Weinstein, 1982), however criticisms such as Goffman's are credited with helping to bring about deinstitutionalisation (Teig, 2012:51-52). Post-deinstitutionalisation, others have questioned whether the structural principles that maintained the "total institutions" that Goffman and Foucault criticised are still to be found in hierarchical health systems and the service user/service provider or doctor/patient relationship today (Goodman, 2012). An example from the Norwegian context is in the increasing use of *tvang uten døgnopphold* (cf. Weber et. al. 2016), whereby treatment can be administered in an individual's home, without sectioning, which has been described as "the structure of the hospital moving to the living room" (Nasjonalt senter for erfaringskompetanse innen psykisk helse, 2015, cf. Goodman, 2012). Goodman (2012) argues that the way in which health and social services are structured across many countries post-deinstitutionalisation can actually help "totalising organisations" to form within them, and also suggests that variations in community-level care, with many service users in the UK as in his example receiving inadequate care from other types of organisations and being "hidden from civil society", are representations of the total institution being played out in the modern system.

> Although the total institution was manifest (often literally) in concrete form, its social processes are not. They arise from human interaction, which itself both constructs and is constructed by individuals based on their values, culture and taken-for-granted social practices. As Foucault, among others, reminded us, these also operate within a matrix of power relationships. Thus, demolishing the concrete does not necessarily demolish the social: the totalising processes may simply transfer to new concrete settings. (Goodman, 2012)

The Norwegian overall mental health and substance disorder sector

The overall Norwegian publicly funded health system is made up of the primary health services (*primærhelsetjenesten*), which consists of general practitioners, emergency rooms, home-based nursing services, *primary* drug treatment services, and the specialist health services (*spesialisthelsetjenesten*), which consists of specialist doctors, paramedics, hospitals both public and private, district medical clinics and drug treatment institutions (Helse- og omsorgs departement, 2014). Primary health services, for example general practitioners, are under the responsibility of the municipality and that municipality's funding and the regional health providers have responsibility for the specialist health services, including hospitals provided to that regional population (Helse- og omsorgsdepartement, 2014). Norway as of today has a large public sector that emphasises state values, equality and non-economic values (Bjurstrøm & Christensen, 2017:159). The publicly funded social welfare state that aims to realise subsidised health care for the entire population (Borg & Kristiansen, 2008:531). There are different systems in place within the social welfare system itself (health, residential care, aged care, child welfare, et cetera) that often work together *with* the health system in particular cases but are deemed separate and have their own measures within the welfare system as a whole (Helse og omsorgs department, 2014). Politically, Norway has a two-tier system of local government with municipalities (*kommuner*) as well as regional or country governments (*fylkeskommuner*) (Baldersheim, Rose & Sandberg, 2017:197). Since 2014, local and regional governments have been in a state of substantial change due to reforms that would over the following years reduce the number of overall municipalities in Norway, merging several neighbouring municipalities together – some willingly, others under duress from the state (Espedal, 2016:1). Norway's system of local government is generalist, meaning that all municipalities are required to perform the same tasks, with few exceptions, and they have a variety of responsibilities including public health and provision of social welfare (Espedal, 2016:1-4). This has led to political debates over municipal requirements when they vary greatly in size: there has been a pattern of sharp growth in population in certain areas, while others have become markedly smaller, to the point where questions have been raised about lack of professionals to carry out certain tasks, and limited funding (Espedal, 2016:1-4). Since decentralisation of the welfare state in the 1980s and 90s, council reformers have been concerned with scrutiny of decision-making bodies, representativeness across councils for minorities and gender, and increased involvement in decision-making but also issues concerning corruption (Baldersheim et al., 2017:197). Municipalities and regions in some areas are now the largest local employer, and enjoy a significant decision-making role, also

necessitating that local authorities are in constant debate about how to best organise and manage councils. (Baldersheim et al., 2017:200) Baldersheim et al. (2017:200) suggest that that a key issue for these municipal and regional authorities is managing “capture” (issues arising from overdominance of administrative powers) versus “responsiveness” (avoiding bureaucratic inertia in large organisations, particularly in the public sector, which can result in population neglect).

On service-users

Current estimates state that around 18-22% of the Norwegian adult population will experience some kind of mental illness in a twelve-month period, most commonly anxiety disorders, depression or substance dependence disorders (Reneflot et al., 2018:20). The Norwegian department of public health suggests these percentages are relatively stable around adults, whereas younger adolescents, particularly girls, show an increase (Reneflot et al., 2018:8-10). Other media sources suggest that overall, referrals to specialist mental health services (DPS) are increasing, with around half being for young adults (Fagerbakke, 2019). Recent surveying of Norwegian university students suggests a sharp increase in incidence of mental health difficulties (Knapstad, Heradstveit & Sivertsen, 2018:4) Occurrence of mental illness has been demonstrated higher in those with an immigrant background than in ethnic Norwegians, and the Department of Public Health suggests that many immigrants do not receive proper treatment, or seek treatment, as should (Reneflot et al., 2018:7-8). Certain types of substance use disorders, particularly alcohol abuse, have increased in recent years, while others remain stable, although overall researchers lack substantial data on substance dependence in the Norwegian population (Reneflot et al., 2018:7-8; Landheim et al., 2016:30-31). Available studies suggest that only a very small number of those who meet the criteria for having a substance use disorder receive treatment (Landheim et al., 2016:31). It has been shown that substance use issues are more likely to occur amongst individuals with mental health issues than in the overall population, and comorbidity is high, with some individuals experiencing mental health issues prior to developing substance use issues, others experiencing mental health issues as a result of long-term substance use (Landheim et al., 2016:33). As a result of awareness around the high comorbidity of these types of disorders, specialised and parallel treatment methods that incorporate recovery-oriented perspectives have become more common in the specialist health services (Landheim et al., 2016:33-34).

Recovery-oriented services within the municipality of Bugard

When considered in the context of Norwegian recovery, the municipality in question does stand out in terms of programs and services available to individuals struggling with mental health and substance dependence difficulties. Even if the 'levelling of power' through inviting several differentially positioned actors to take part in meetings, such as the one described earlier in the chapter, may be more difficult in practice than in theory, the fact that it is happening at all is radical, and especially stark when viewed in historical and social context. As an outsider to these systems, I asked some of my interview participants on where the recovery movement locally had grown from. Informant H., an 'expert by education' offered the following reflections:

> *I came to a large conference via [name of research organisation] where there were experts, users and caregivers together. Users and caregivers gave a seminar which gave me the greatest impression in that symposium, it was the "Hearing Voices" network in Scotland holding a workshop for psychiatrists. There they demonstrated completely practically how it was to hear voices. Suddenly, the professionals sat behind the school desk and learned from those that had lived experience. Then, we were right at the beginning of the Mental Health Escalation Plan which went from 1998 to 2008. Ten years, with major changes in the mental health services within Norway. All the psychiatric long-term patients that had been in psychiatric institutions for many, many years, and likely had no perspective on that they might move, would suddenly get permission to live out in the municipality, in one way or another. Out in society, away from institutions. Then came large economic transfers to the municipalities, and many new assignments. Mental health would now undergo a complete reconstruction, to become a place where they would have active treatment – either via outpatient clinics or hospital beds, but there would no longer be the long-term residential or caring function they had before, for those that had not yet become well.*
>
> *Now the municipalities would do something they hadn't done before, and they didn't need to copy what had been done by the specialist health services. We travelled to gather inspiration from other places. Back then, we were most inspired by Denmark, as Denmark had always had an environment that was in a way, "experimental", actually – for that time, experimental, whereas the general psychiatrists in Denmark were very traditional and medicinal…"*

We looked at different things: residential services, employment programs, art and culture programs. We had a historic opportunity to think – here can we create something new! Back then, we were very interested in the environment at the University of Boston, who had a specialist competence centre for mental health, and we had invited conference holders from the USA, from Denmark and England to come and try out these ideas in a larger area such as Bugard, not just for those who had travelled around. We wrote something for the first time in 2007 in a plan for mental health at the municipal health services in Bugard, should work recovery-oriented. Very many at that time did not know what that meant. But, this was very important in changing the political landscape [around recovery], now that the city council stood behind it. (Informant H., 'expert by education')

Today, the department in charge of municipal policy and services in the area of mental health and substance dependence operates and manages at the time of writing a series of decentralized suburban service centres, each with a department head. This system is set up so that each of the suburban department heads report back to and act on the behalf of the municipality. Each of the suburban department heads has responsibility for a number of low-threshold and high-threshold centres, activity houses, local psychiatric divisions or housing facilities.

The municipality has proactively followed up national recovery-oriented recommendations and has employed "experience-consultants" in their services, many of which have undertaken the so-called MB-education. The MB-program (MB is an abbreviation of *medarbeider med brukererfaring* – employee with user experience) is an educational program designed to train former service users with lived experience to work in mental health and substance use care services, converting their experiences into competence (Helsedirektoratet, 2011). User employees with and without MB backgrounds are attributed today important roles in recovery-oriented mental health and substance dependence care nationally and locally, including here within Bugard recovery college. On a regional and national basis, a limited number of employees work with and without MB training, for example in the mental health and subsistence dependence field in the municipalities, social welfare system (NAV), within the specialist health service, as co-researchers, in councils and committees and in the health bureaucracy at various levels of organization as well as within user organizations (Rydheim and Svendsen 2014). Their work assignments are similarly diverse and can range from

everything from agency-level planning to co-research and participation in research-based evaluation reports and guidance from service staff. Many have direct contact with current service users and caregivers and perform many of the same work tasks as other employees, such as in treatment and activity programs in the services (Helsedirektoratet, 2011). The MB-program, beginning in 2005, received funding through the Mental Health Escalation Plan 1999-2008 (Helse- og omsordsdepartementet 1998). Many MB-program graduates are in various ways engaged in the development of the recovery college program.

Among recovery-oriented services in Bugard also figure activity centres, along with other low threshold meeting places facilitating physical activity, art work and other activities which are wholly or partly financed by the municipality. Such services can be found in each of the suburban departments. Hence, the recovery college complements a series of recovery-oriented services within the municipality of Bugard. The recovery college itself is placed as a cooperation between the specialist services, here for anonymity reasons called Helse Vangen, and Bugard municipality. Helse Vangen also utilises experience-based competence within its services, with two panels of previous users from both mental health and substance dependence departments under Helse Vangen, as well as others employed in diverse positions across various departments. Substance dependence is an area in which the municipality is investing in recovery-oriented services, both low and high threshold. Locally, a number of measures have also been taken in recent years as a cooperation between the municipality and the health services in order to address particular issues around substance use and mental health, such as proactively addressing the issue of open drug environments and illicit drug use, establishing further low-threshold reception, activity and health centres, expanding medically assisted withdrawal programs, continued residential solutions for homeless persons, and so forth. This involved cooperation with Helse Vangen and the local police, among other parties.

Policies and challenges in the mental health and substance dependence sector

Municipalities, counties, councils and their ilk are part of the political system as well as the public service. There is often a difference between what political parties at different levels argue for when in power, and what kinds of recovery reforms and aims could be emphasised in various white papers, and what kinds of concrete change, along with sufficient financial backing trickles down to the localities that actually have the job of dealing with the everyday mental health and substance use services. There has without doubt been widespread policy change in recent years since the deinstitutionalisation movement in Norwegian psychiatry and internationally, towards active inclusion of experience-based competence, user participation

and user perspectives, and peer support principles.[8] Integral policies are for instance the Mental Health Escalation Plan (Helse- og omsorgsdepartementet, 1998) and the Cooperative Treatment Reform (Helse- og omsorgsdepartementet, 2009). Current national policy on health and hospital planning mentions specifically several points with reference to either recovery or the importance of competence (Helse- og omsorgsdepartementet, 2016). The policy directive "Together on coping" (Helsedirektoratet, 2014) emphasizes that the user is the most important player in the design of service offerings, focusing on prioritising users' perspectives, desires and aiming for overall improvement in life quality rather than clinical health improvements. The importance of coordinated services and the maintenance of a holistic perspective on improvement is emphasised. They also state that the "insider perspective" is not something that can be studied without experiencing it directly and thus represents a genuine form of knowledge, different to that of professional competence, but equal in worth and complementary in use (Helsedirektoratet, 2014). This is an example of utilising a recovery focused perspective whereby the service user is centralised and viewed as a consumer with agency, rather than a problem to be treated, and also highlights the significance of users' own 'competence' in having the ability to set and work towards recovery goals with the assistance, rather than instruction of healthcare providers.

Variegated responses in the practice field

Policy changes 'from above' may receive variegated responses in the practice field. As informant J. describes, experience consultants faced considerable resistance when new, yet has since been an agent for formidable change:

> *The MB education program was started in order to educate recovered users to be helpers. At that time, there was great disagreement about whether it was a good idea. We saw that the different services and departments, have quite large differences in opinion. Some were very engaged, wanted people in work experience, wanted to hire them, yet still others were quiet as mice, and thought it would all blow over.* (Informant J. 'expert by education')

Despite initial reluctance, J. was very positive about the pioneering shift in the culture of the services overall, owing to, among other things, the positive effects of preparatory programs such as that of the MB-program. Others again were more cautious of whether the services were truly recovery-oriented: One informant, M., categorised a kind of *"passive*

resistance" throughout some areas of the services, stating that *"If you ask people if they are or [the services] are recovery oriented, you will not find anyone who is in disagreement."*

This illustrated that the presence of experience consultants and their ability to exact change and assist users can be affected by traditional defining powers, social control, and dominant perspectives around "ownership" in psychiatry and definitions of recovery (Davidson et al. 2005; Davidson & Roe, 2007; Ekeland, 2011; Borg et al. 2013). Biong (2015) points out that professional employees "must be reoriented" both with regard to content in the services, relationships, roles and forms of contact. Elvemo (2008) points to a tendency within municipal health services to operate on a basis of professionals knowing best.

Influential persons within local services in different areas, differ in their own values and ideas about which reforms to push for. Much of this is arguably down to bureaucracy and the ability of a municipality's staff to negotiate for desired reforms, such as greater focus on recovery. I asked J., an 'expert by education', where the idea for the recovery college specifically, not just working recovery focused, had come from politically – what kind of discussions were being had between local government and the services about why this type of service was necessary for Bugard's community? He replied that in their case, rather than local government officials pressing for specific recovery reforms, that the concept had come from "*scholarly and research backed interests*" that caught the interest of politicians. Key figures in the establishment of the college had long held interest in recovery-oriented working and theories of recovery and empowerment, heavily influenced by Slade and international models in England and Denmark, which was repeated in several of my interviews as having led to the overall move towards 'recovery' within the municipality, and the establishment of this kind of history was able to be backed solidly by recovery theory and knowledge, from within an increasingly larger scholarly field over the past decade. So in their case, she argued, having a strong theoretical understanding and having reference examples from the growing body of international recovery colleges solidified policy and funding.

Other informants whom I talked to, worried about the demise of user-perspectives when confronting EBP standardization (evidence-based practice) in the practice field, and especially as it relates to medical interventions. Interestingly, despite recent health policy guidelines promoting inclusive of competence-based experience and increased presence within services, there is an increased standardization of services and reliance of evidence-based, professional perspectives according to Ekeland (2011, see also Bøe, 2007). This, combined with regulations

on patient care, financing and time spent, characterised by new public management, can be a bone of contention for users (Debesay, Harsløf, Rechel & Vike, 2011; Askheim, 2016).

NPM and fragmentation

Policy reforms and restructuring of the public sector, including the health sector, in recent decades have been criticised for causing "fragmentation" and "over-management" in the health system (Teig, 2012:27-28), and these restructurings have also been criticised for making the system more difficult and complex for service users and their caregivers (Borg & Kristiansen, 2008:514). The problem of coordination between various services across the municipal and specialist health services, and especially with respect to concomitant mental health and substance dependence problems, is addressed both among the users of services (Landheim et. al., 2016:150), researchers (Borg & Kristiansen 2008:513) and in state-level and municipal-level white papers and policies. The coordination between actors such as NAV (social welfare), doctors and the municipal services is not an easy task either. Certain services are designed to in some way assist service users in navigation of a complex system, such as ACT (assertive community treatment) teams, which assist with treatment for both issues simultaneously, and assist service users and their caregivers through a variety of services, such as residential programs, social programs and meeting with medical professionals (Landheim et al., 2016:34).

New Public Management has contributed to this process. Since the 1980s, structural shifts in the public sector have been influenced by NPM reforms (Teig, 2012:28-29).[9] This refers to local governments emulating concepts and practices taken from traditionally corporate cultures such as increased focus on performance and results, and managerial roles, as defined by Bjurstrøm & Christensen (2017:159-160). The neo-liberalist and more fragmented model of the state in NPM favours strong decentralisation of services, introduction of more private service providers, delegation and more managing roles, and above all more cost-effective state services (Bjurstrøm & Christensen, 2017:159-160). Many have been critical of NPM within the health sector, citing among other downsides worsening of clinical services, worsening of work environment for health personnel resulting in shortage of medical providers, economic inefficiency and focus on pure profit, and at its extremes, dehumanisation and demoralisation of the health system and its values (Wyller et al., 2013).

Authoritative measures: Assessing rejections, the use of force and risk

According to Renedo & Marston (2015:488, referring to Cornwall 2002:2 and Kesby 2005), "Policy and academic discussions of participation are permeated with spatial metaphors

(e.g. ‘opening-up’, ‘widening’ ‘arenas’ and ‘spaces’ for public involvement, citizens gaining ‘positions’ of influence)”. Simultaneously, patients in mental health care continue to experience restrictions with respect to getting help when requesting it, while yet others are made subject to enforced medical interventions and confinement. Despite reforms across the overall Norwegian health system, issues around meeting the needs of substantial numbers of vulnerable individuals within the mental health and substance use system are still prominent. Two areas of concern worth highlighting are difficulty in receiving help from the specialist psychiatric services, and use of force, which may relate overall differing ideas about ‘risk’ in regard to recovery. A 2015 study reported that many thousands of patients who had been assessed by their general practitioners as requiring psychiatric assistance from the specialist mental health service (DPS) were routinely rejected without further investigation (Storvik, 2017; Holman, 2017). Rejections were notably twice as high for those seeking mental health assistance as those presenting with physical complaints, and Holman (2017) blames political motivations around reducing waiting times for specialist health services as a cause for increased rejections.[10]

Use of force within the health system, particularly within specialist psychiatry, is still a concern, whereby professionals exercise considerable power and, in some cases, override the autonomy of service users. For example, the increasing use of TUD (*tvang uten døgnopphold* - force without admittance) whereby treatment can be administered by force without sectioning, for example in home settings, has been criticised in recent research (cf. Stensrud, 2016; Lorem, Steffensen, Frafjord, & Wang, 2014). Patients experiencing such measures have been shown to be disadvantaged economically and socially (Helsedirektoratet, 2008:11). Control committees including ‘experts by experience’ now exist to review complaints and decision-making regarding the use of force (Helsedirektoratet, 2008:18). Involuntary admittance to psychiatric treatment or sectioning is in many health systems the traditional response to presentation of serious mental health crises and has been linked to worsened self-image and hindering long-term recovery (Slade, 2014:182). A study by Aasland, Husum, Førde, & Pedersen (2018) demonstrated significant differences between mental health personnel and attitudes around authoritative measures and use of force, with likelihood of preference for authoritative measures following to a certain degree the systemic hierarchy: psychiatrists were most likely to express preference for forceful measures, followed by registered nurses, followed by other types of health professionals[11].

Part of the larger discussion around authoritative measures, and more traditional clinical perspectives where service providers have a higher authority, centres around 'risk', a key tension present in the movement towards recovery-oriented working whereby individuals are given more responsibility over their health and wellbeing, and service providers must give a certain level of authority to the service user. Clinical culture has a longstanding relationship with the notions of responsibility, care and acting in the "best interests" of those with mental health or substance dependence difficulties (Slade, 2014:176-177). However, as demonstrated by the previous two examples, and throughout history, clinical authority over what those "best interests" are has not always had a positive outcome. The discussion of risk invariably betrays the discussion of attitudes around violence and mental illness, the relationship between has been largely over demonstrated both in scholarship and in media portrayals of mental illness (Stickley & Felton, 2006, Slade, 2014:177)[12]. Moreover, discussions of risk, best interests and best outcomes, and decision-making in many situations still operate via power discrepancies. These discrepancies are not personal, and the efforts of more radically-minded individuals in authoritative positions can make great strides, as demonstrated in a variety of initiatives for the Bugard community.

Concluding this chapter

According to Brown, Crawford, Gilbert, Gilbert & Gale (2013:3849), "a key sociological insight is that healthcare – especially mental healthcare – is an exercise in power" (see also Foucault 1977). The history of the treatment of individuals with mental health and substance dependence difficulties is a confronting one, and the recovery moment – and the recovery college with it -is a long way removed from the total institution of times past. Yet institutions and hierarchies are manifest in the field investigated. It is part of what is taken for granted in everyday life among the parties involved. In the Bugard recovery college and other recovery-oriented services employing co-production, experiences of asymmetries and discrepancies between the parties involved are sought to be 'bracketed off'. Yet, according to Bennetts et al. 2011 (in Brown et. al., 2013:384), "…despite recent interest in user participation there is a concern that the power structures have not been genuinely subverted." Although much has changed, service users may find themselves in vulnerable positions and locked within asymmetrical power dynamics. Moreover, different mental health reforms may stand in a difficult relationship to each other, such as recovery and empowerment measures versus EBP. Developments and reforms within the health and social system have not always been positively received in the practice field, with the issue of new public management a particular concern.

The recovery moment in health reform exemplify how hierarchical structures are sought modified by agents within the structuring structure itself, however, changing cultures as well as attitudes can be more difficult than anticipated in governmental and municipal white papers. As Bourdieu (2017) argues: what is taken for granted in the hierarchical order is structures of symbolic power, which are reinforced by actions:

> If the state is capable of exercising symbolic power, it is due to it simultaneously falling into the objective, in the form of specific organisational structures and mechanisms, and in the subjective, in the mental structures and categories of perception and thinking, that the state realises itself in social structures and in consciousness structures adapted to them, this instituted institution makes us forget that it springs from a wide range of institutional actions (in the active sense) and is therefore experienced as nature (Bourdieu, 2017:231).

The conceptually radical project of a recovery college is still required to fit within the complex and hierarchical system of mental health and substance dependence services, albeit ‘bracketed off’ from the municipal structure and the everyday life of asymmetries between the parties involved, this presenting opportunities and challenges for the involved parties.

Chapter five: The magic of recovery in co-production

Introduction

A theme that came up more than once throughout the course of my fieldwork was that of 'magic'. The term seemed to be used when someone could not necessarily find the words to describe something considered unbelievable, somehow supposing to summarise an idea or concept that could only be felt or experienced rather than captured by ordinary language. This word came up repeatedly across different fieldwork situations. Was the process of 'recovery' or 'co-production' what they were experiencing as 'magic', and what did 'the magic' refer to? The following excerpt is an example from a meeting setting:

> *It is late spring; the meeting room is crowded with representatives from the project group. The latest co-production event is recalled with excitement, and one participant ('expert by education') exclaims: "It is simply magic! Co-production – that is where the magic happens!*

After a few encounters where I had noticed the term recurring, I decided to analyse all the key occasions on which it occurred, to see if it always referred to the same type of event and try to contextualise what this 'magic' referred to. So, what was 'the magic' about co-production? What did 'the magic' entail? How is "the magic" and recovery connected? Why choose the metaphorical term magic rather than describing an experience as thrilling, wonderful, exciting? What did this word capture about the essence of these experiences? In this chapter, I reflect on 'the magic' in relation to coproducing recovery.

What is in the magic?

Linguistically, the term 'magic' has a variety of interrelated meanings: such as these as "the use of [or the possession of] special powers to make things happen that would usually be impossible (*"as if by magic…"*)", "a special and exciting quality that makes something seem different from ordinary things"; "…making things seem to appear or disappear"; "happening in an unusual or unexpected way, or easily or quickly (*"there's no magic solution to the problem")* (Magic, n.d.). Magic is also linked by definition and often in people's minds to otherworldly or supernatural occurrences – i.e. things that would usually be impossible. In broader terms terms, the word might be used in everyday speech to describe feelings or experiences, however while falling in love might be expected to feel like 'magic' and seeing a stunning fireworks display can be a 'magical experience', the employment of the term in an otherwise very professional setting is interesting. It is not difficult either to find associations

between mental illness and magic, for example the experience of unreal realness of psychosis (Laws, 2013:345). Pre-psychiatric medicine's conception linked mental illness with magic and demonic influence (Foucault, 1964).[13] Other scholars have also reimagined 'magic' in other areas parts of the recovery movement, as outlined by Laws:

> ….'magic' thus offers some justice to the work that appears in delusions, by showing what is creative and productive in psychosis, as well as is what is incalcitrant and perverse. Through stressing a *surplus* rather than absence of meaning in the work of psychotic people, 'magic' articulates what is public about private madness (Laws, 2013:345).

However, 'the magic' in the context of the recovery college's co-production settings, pointed to a range of possible interpretations that seem to read again anew, in contrast to these earlier offerings, as I will discuss in the following.

Magic evoked - a personal interview

I heard the word magic for the first time when interviewing one of the key individuals (hereafter referred to as R.) involved in the set-up of the project, whereupon she mentioned it more than once. Here she used the word 'magic' to describe for instance the positive effects produced by the set-up of recovery college classrooms. Specifically, she referred to how the balance should be struck between those with experience as 'service user', and those who would have other types of competencies and perspectives, such as other municipal staff who joined purely because they were interested. "*That magic*" was something that she related to having experienced together with other representatives from the municipality (one with user experience background, and four altogether with bureaucratic or other non-experience background) when attending one of Nottingham Recovery College's courses some months prior. Yet, whilst the types of competencies, roles and skills that those coming into the co-production environment were deemed to be crucial in determining that the space could be an equally balanced and democratic space, they were also simultaneously described as "*disappeared*". "*That magic*" itself, she defined explicitly as

> *When everyone in a way lost their label, and it became clean, complete, concrete equality. The magic was at it became this way due to the manner in which the course was structured. So it was completely automatic. … everyone experienced that same magic…you let go simply of other things, and you were there to learn something.* (R., 'expert by education').

She foresaw that the courses of the Bugard recovery college could include around thirty-six participants with mixed competencies in the first round, spread out over three courses: "*We desire to control it [the process of student intake] slightly, in order to achieve that magic, that we ourselves experienced when we attended a course*," were her exact words when we spoke about the '*balance of competing competencies*' in the classes, early in our interview.

She went on to describe a sort of unravelling of what she termed the "*power relation between specialist and those that will be helped*".

> *It can be experienced when you are mentally ill, and go to your doctor, and it is decided [for you] what medicine you are going to take, and it is not explained why. This same experience can happen to so-called 'educated individuals' when we go to our own doctor with the same [issue]. That feeling is so universally alike, with us. [In Nottingham] we were just as eager, all of us, and it was wonderful for [someone who was typically in this role professionally] a helper, that was used to being a specialist, to lose that role completely.*

The overall course group was led by one experience-background teacher and one education-background teacher who were able to steer the composition of the groups in a way that encouraged this diversity but yet seemed natural and not forced. She emphasised repeatedly the "*magic feeling*" in everyone that occurred when this was done, this kind of 'role removal' of one's usual everyday role, whether as system provider or 'service user' in some way or another and experience this atmosphere of '*equality*'. This was one of the key experiences that gave way to the idea of setting up a recovery college in the municipality, and this "*magic*" was what they were most enthusiastic about replicating by using the same kind of course structure as Nottingham.

The spread of the word magic

During meetings with representatives from Nottingham Recovery College, there was a debate in plenum concerning how to prevent excessive "*illness talk*" (loosely thematized as overly focused on negative aspects of illness, difficulties in recovering, and so forth) in the classroom while still emphasizing that the classroom was an open and accepting space for expressing varying types of experiences. One of the Nottingham teachers argued that the diversity of competencies in the classroom ('experience-based' and 'education-based') naturally combatted negative "*illness talk*" seen to be detrimental to a positive recovery-oriented focus. Informant R. had further thoughts on these themes, reiterating some of the points she mentioned in our

interview during the plenum, such as when she for the first time been invited to participate in introductory co-production settings at various international recovery colleges. In her words: "*No one knew who in the class was who, even the teachers did not know who had what type of experience. That was … the magic*." (Informant R., 'expert by education'). At the final project meeting summing up the first semester's pilot run, I noticed some individuals were beginning to make the reference to 'magic' who had never used the term before at any of the meetings I had attended. Therefore, I wondered – had the term spread to become not just a description of a desired effect of coproduction but an enshrined and perceivably necessary goal of co-production work? Was co-production deemed less valid, balanced or democratic if it could not be decidedly argued as magic? This was a clear example to me that the term "magic" had gone from being a throwaway term or descriptor, or something expressed by just one individual, to being part of the college's own lexicon, like a mantra offering a summation of certain key aspirations of co-production for the college.

Expanding on a theme: Is recovery itself 'magic'?

It does not seem that unrealistic - when thinking about the definition of magic - that the experience of recovery could be experienced as 'magical', if individuals have spent a long time believing that they would always be affected by their condition or experiences, frustrated over relapses, and so forth. Fox (2018) posits that common threads in stories of recovery are loss and isolation (in the state of 'unwellness') and connection with others as a healing force (Fox, 2018). She uses terms such as 'magic' and 'myth' in an almost supernatural conceptualisation of 'recovery':

> Elusive, intangible, magical, recovery is, at best, something to be hoped for, though not necessarily to be believed in. After all, you can't see your recovery, you can't touch it, as you can a healing wound. Recovery suggests that you can get back to where you were before, which is to say, back to your old self, your well self, your whole, unwounded self. As such, it is a dark word, as well as a magical one. It is the mythical tree in the fairy tale forest that has the power to protect you or crush you. Recovery is teamed with the verb "to recover", and to recover means to retrieve your former self, to find what you have lost. But with recovery, you cannot go back. Instead, you need to let go of your old self or your old way of living, and to accept who, and what, you have become, and to live differently. To recover, you need to be able to see a future with you in it, you just as you are, however changed, damaged, flawed or fearful. This is what recovery looks like, and another word for it is hope. As well as hope, you need resilience

> because, as all the people I have spoken to have said again and again, you're still on your own, and because the thing that took you down might come back (Fox, 2018).

The conflict present in Fox's illustrative conceptualisation is that there is a type of "recovery" that rests on expectation and misguided belief that after one "recovers", they will be the same as they were before they became 'different' or 'damaged'. Fox seems to suggest also that recovery is *only* as successful as the individual's efforts ("you're still on your own"), and states that relapse is almost inevitable ("[it] might come back"). Here there is a fundamental conflict – that recovery is "elusive", challenging and almost esoteric, difficult to achieve and even more difficult to describe; yet also something that the individual should strive for in themselves, requiring just the right amount of resilience and hope, as well as efforts in daily life, to achieve. Problematically, this kind of thinking idealises recovery as some kind of prophetic or mystical goal to be reached in order to 'regain' one's status in society. Perhaps this may also, as Davidson et al. (2005:486) suggest, reinforce pressure that all individuals must recover in a certain way. Do conceptualisations like this further stigmatise relapses as 'failures' and make it more difficult for individuals to recover by focusing on the almost insurmountable challenges and "mystical" nature of being truly "recovered"? The way in which metaphors and symbols are intertwined represents more than just figures of speech: they may become part of the experiential realities of people's lives (Lakoff & Johnson, 1980).

The not – so – magic of recovery

Fox's (2018) individual histories cited similar themes to many of my informants throughout my fieldwork in terms of key factors in their recovery: social connection, therapy, exposure to nature, physical exercise and meaningful work/leisure or daily activities (Fox, 2018). However, informants who were 'experts by experience' did not tend to talk about their recovery process in terms of 'magic': This would imply that their recovery was in some way out of their control, something not to be expected which happened anyway. Of all the individuals I spoke to during fieldwork who had competence by experience, I found no instances like this – all credited quite mundane or 'everyday' experiences – often of a social nature - such as going to the gym several times in a week and establishing an exercise routine, engaging in peer support, walking in the mountains together with others, having a regular job and feeling like they had purpose at work or prioritising a healthy diet, – as being the key factors that influenced their recovery. Stories about recovery also often entailed an important person – a person close to the person, a health practitioner, a friend or a random person – who had probed behind appearances, "seen" the person in question, and recognised and believed in the said person's capacity, will and option

for recovery, often expressed as “he or she really believed in me.” (cf. also Landheim et. al. 2016). They also credited recovery to their own hard work, to their own determination and insight, using linguistic hints such as “I started to…”; “I began…”; “I found…”; “For me, it was important that…”. None of these individuals categorised their experiences as ‘magic’ in my encounters with them, but rather in terms of mobilising all resources, capacities and ‘recovery capital (Tew 2012[14]’, in Klevan et al. 2018:17-18) available, including systemic-based cooperation around recovery and themselves as individuals ‘in’ recovery. Their *“turning points”* (cf. further discussion in chapter six) and often boiled down to exercising, eating healthier, going for walks in nature, expressing creativity through music or art, having a job and an income, and having social contact in a variety of arenas. Others related that the recovery college was innovative in that it could encompass these values, and provide a supportive space not to “carry” individuals through their journey but give them a supportive space to challenge and ‘prove’ themselves by meeting for class times, producing homework and participating in co-production. However, I would argue that recovery capital should always be seen in relation *to* structure, agency and social and cultural capital forms: these “turning points” do not spring from nothing, and the social and economic circumstances of service users as context for assessing recovery capital is perhaps a more effective starting point for holistic recovery than a solely individualised, if personalised, focus (cf. Perese, 2007:288-289; Borg & Kristiansen, 2008:512-516).

The ‘magic’ of co-producing recovery-orientation in the health services

It was for the most part ‘experts by education’ who promoted the uses of the term ‘magic’ when addressing recovery and co-production, while ‘experts by experience’ did not offer this term so readily. The latter with intimate knowledge of own process and what it takes to recover, as argued previously, referred to actions they undertook themselves which were perhaps for some ‘magical’ in that they had long-lasting effect, but were fundamentally characterised in their usual and everyday nature. These were their “turning points”, as I will expand on further in the next chapter, and a key focus of coproduction settings for many ‘experts by experience’. Recovery researchers presuppose the complementarity of competencies although often expose how diverging recovery philosophies may be at odds with one another in a variety of healthcare settings, for example when arguing for cultural and organizational change (Biong, 2016).

This also leaves room for differing interpretations of the ‘magical’ nature of co-production and the capabilities for change this process is presupposed to have. According to Askheim (2016), co-production measures have been implemented in the services from the

1990s health reforms and onwards, especially by way of the emphasis put on user involvement and partnership between service provider and service receiver.

In the duration of fieldwork, I had countless conversations, both in interviews and other settings where individuals discussed the overlap of their competencies and the problematics of trying to extricate competency forms from each other, as the reality of using competence in practice was far more mixed. The inclusion of diverse forms of competence, including that of lived experience, within the health and political arenas is, as mentioned, not new, or only present due to the recovery movement[15]. However, experience-based and education-based competence still may find themselves as polar opposites rather than in a relationship of complementarity in the everyday working reality of mental health service providers. Klevan et al. (2018) argue that a continual challenge for those working with 'competence by experience' is that of assimilating to the dominating culture within the health system that preferences theory-based knowledge to a degree that experience-based knowledge can be further recognised as a legitimate form of competence, yet not be marginalised and 'swallowed up' by theory-based knowledge. They describe the extra labour required of that those working with experience-based competence undertake continually in order to 'hold their own' against the dominating preference within the health system for theory-based knowledge:

> …Experience workers have to work all the time towards experience-based competence finding its own place and being recognised. This work can be a lonely experience because it is about finding a place inside, at the same time as it is also seen as important to defend a position outside (Klevan et al, 2018:56-57).

This 'extra labour' in promoting the value of experience-based competence within a theoretically or professionally dominated municipal space was reflected across interviews, and in the following I will present an interview with G, an experience consultant with a good deal of experience working with the development of this project and other related projects.

Bringing forward the user voice in a service department: reflections by G.

One informant, G. ('expert by experience') talked at length about what it takes to bring forward 'the user voice' in the practice field of the municipality's health services. He mentioned early during an informal interview that he had noticed an increase in positive attitudes towards the inclusion of the user perspective among his colleagues after an initially slow start, and that some colleagues were quicker to adapt than others who had some difficulty.

I asked him if he could be more specific on the kinds of difficulties that he and others who were trying to bring forward the user voice had encountered; he said that over the past few years of promoting recovery-oriented working across different services, the significant difference had been via the leaders, or department heads of the upper echelon of the bureaucracy, and their management styles, and crucially, the kind of value they attributed to the 'newer' ideas about recovery.

> *If managers are very engaged in being recovery-oriented and [continue to] create, maintain pressure and stand for its promotion; then the services become more recovery-oriented in that sense. When managers are slacking, or not bringing it up that often, I think that the services fall back to the old norms and ways of working."*

He spoke also to the difficulty of being the one seen as representative of the user voice and perspective in the work environment, especially when being the only experience consultant working on a department:

> *It is difficult to bring forward the [user] voice alone. When I sit with fifteen that have work experience and school experience that they use in their work, then I stand very alone with that user voice… [ ] We didn't talk about these things during the [preparatory] program, we are going a new way now (with recovery-oriented services) … I think in a way, this is growing pains*."

He was quick to assert the positives of the most recent developments despite these "*growing pains*", including the effect of the increased visibility and collaboration between experience consultants, meaning that numbers of experience consultants at each department were likely to see an increase in the near future. For him, this was a key component to the services becoming more competent in recovery, as well as being significant for those individually who were employed:

> *We experience that, those who are increasing in numbers [at each department], they have greater quality of life, and greater job satisfaction. I believe that to be true*."

He also spoke to the concept of shared work values linked to positions and related competencies, describing that, typically,

"care workers, they have their fellow care workers, nurses, they have their fellow nurses, and I think it really has to do with shared values and philosophy. They have a philosophy they base their work around, and particular values. And I... stand alone with my philosophy and my values. So, when we are two or more, it becomes easier."

For him, these concepts: quality of life, and job satisfaction, were linked to not feeling 'outnumbered' at work and feeling '*listened to*'; as well as being positively recovery-oriented for those individuals and the services overall.

In the following, I will briefly reflect on G's outline taking inspiration from Bourdieu's (1977) framework, as accounted for in chapter two, with respect to social field, forms of capital and the concept of habitus. G. draws contrasts between experience consultants and their related values and competencies, as against those of various categories of 'experts by experiences' with their related values and competencies. In his own department, he associates each of these layers of solidary professionals with distinct 'philosophies' as against that of his own. He also reflects on the role of the upper management in pressing for recovery-orientation downwards into the practice field; if they do not stand for it across time, the services will easily return to the old, habitually inscribed ways - and experience consultants will by implication be restricted in their effort to promote their special recovery-orientation, as against that of others.

Here G. is indirectly painting a picture of a layered social field, with differences in professional positions, related competencies, values and philosophies the layers in between, and with the management (the upper echelons) setting the rules of the game, albeit not without facing potential challenges in terms of competing understandings, reluctance or even resistance when promoting change; the latter related also potentially to the changes in habitus implied (to new ideas and practices regarding recovery). This is a slow process among professionals owing to different reasons: For instance, experience consultants occupy ambivalent positions and roles in this layered system which is defined principally by educational achievements and cultural capital/competence. The cultural capital of an experience consultant is related to that person's achievement in managing his/her own mental health and/or substance dependence problem; a problem that the professionals are per definition educated and qualified for treating professionally, owing to their education. Now, the experience consultant is put in a position in which he or she is employed partly in order to change from within the existing recovery philosophies and values of those educated in order to treat him/her at the outset, and hence also

to challenge the asymmetries involved. This is a situation that reflects "profession stridence/disagreement" (cf. Slagstad, 2012) and competition, when roles are turned on their head in a social field in which cultural capital (via education) is a main determinant of relative positionality, and where certain philosophies of what recovery-orientation is all about, follows from the forms of education (and capital) in question. If the overarching tendency for both parties ('experts by experience' and 'experts by education') is to focus on the polarity between these types of competence, rather than work towards a common understanding that both can assist in a deeper understanding of the overall mental health field, the likelihood is that experience-based competence will suffer negative consequences, as the (relatively) newer and less 'authoritative' form of knowledge. Related to this issue, scholars have expressed concerns around assimilation rather than integration, of experience-based employees adapting to the environment by utilising "cultural codes" and the "theoretical language" of the theoretical professionals' landscape (Vandewalle et al., 2016, in Klevan et al., 2018:57). Alternatively, experts by experience will urge a decrease in the uses of theory language. This will be discussed further in the next section.

Communicating well across competencies: the course in health pedagogy

Informant F. ('expert by experience'), in an interview, emphasised the importance for simplicity and accessibility of language ("*user voice language*") and abbreviation-free lecturing in co-production settings. In a later interview it was argued that it was very easy for the 'expert by education' to overcomplicate the course material during co-production:

> *I see in any case that I need to put the brakes on* (F. names an 'expert by education') *with all her theories and thinks like that – amino acids, carbohydrates, et cetera. I have to say, hey, easy, easy – We have to talk [in class] so that they understand what it is. Keep it simple, stupid, right? I do believe that – make it simple.*

Both 'experts by experience' and 'experts by education' held that the language used in co-production settings was in many respects a good indicator of whether co-production was actually taking place or whether it was more of an emblem or symbol of recovery-orientation among corporate bodies and their professionals.

During the course in health pedagogy that I attended together with a majority of 'experts by experience,' a discussion sprang up around the importance of good communication between individuals with diverse competencies and what exactly this good communication should entail, so that no one would feel misunderstood or that they misunderstood what others talked

about? Several experience representatives chimed in, saying that they often felt like they talked '*one language*,' which users were receptive to, and that other staff or those with competence by education, not experience, were not necessarily completely "fluent" in. Those with educational competence had '*their own language*' or languages themselves. The experience representatives reflected that this, especially in combination with their unique type of work as '*former service user, now employed'* exacerbated the issue of, as one individual described it, "*feeling like you have a foot in each world*."

In terms of how these two competencies should try and communicate best together, many experience representatives expressed that they felt that it was more crucial to incorporate the language of the "*user voice*", and interpret or translate what they defined as "*theory-language*" or ways of speaking that were scholarship-heavy into the more "*service-user-friendly*" manner of expression. They said that while it was important that everyone, regardless of their initial competence, should take responsibility to continue learning about their subject and relevant research or theories, it was also important that '*this went both ways*': that individuals lacking experience competence took it upon themselves to learn about the specifics of that type of competence, and that moreover, everyone felt comfortable to undertake these types of 'upskilling'.

With regards to how these concerns would play out in the recovery college, some user representatives felt it would be useful to have a user or experience representative in each group from the development process, in order that students would "*dare to say at they do not understand something, so that the teachers can try to say it in a different way*." Many were also in agreement that "*individuals likely won't dare to ask about things they don't understand the first time at a new course*", and that assumptions should not be made about that those who were less communicative amongst the student group did not understand, or that certain individuals who might come across as being knowledgeable understood the subject matter. With regards to, as they described it, the different "*language/theory-language/communication-dialect*" that exists within user groups that may feel '*foreign*' to those not a part of that group, most of the user representatives felt that the best way to tackle this was not to "*overcomplicate that which can be explained in a different way*". This was reflective of the view expressed by an informant, … , saying "*Keep it simple, stupid*" was ultimately the best rule, and that this was a major part of his role as the "other half" of the development group with user competence: to keep things understandable when those with other types of competency may tend to overcomplicate.

Bridging competencies

It is interesting to point to an oft-overlooked issue with the bridging of competencies involved in recovery-focused working: Experience, either by 'education' or "lived" is not necessarily clear-cut, and there is not always a boundary between different types of "experts". In a personal interview with 'expert by experience', E., she revealed that she possessed both 'competence of experience' and 'competence by education and/or profession,' and she reflected on the impact of this double competency in her everyday work.

E. had completed a preparatory program after her "*recovery journey*" as she put it, in order to get access to a job as experience consultant. She had additionally returned to schooling after some time in the workplace and received a higher education-based qualification as a social worker. She justified this due to several reasons; mainly, she wanted to have, in her words "*more things to fall back on*"; and she wanted to be working on the basis of "*formal competence*," not purely "*experience competence*." She expressed that others' perspectives on her 'role' as experience consultant had been a source of personal concern for her both before and after she gained her formal social work qualification. She contended that since she had gained her social work qualification, she had been asked *less* to use her experience-based competence by her colleagues, however, the service users or patients she was assisting in her work often still saw her as being wholly in the "*experience-based or user competence role*", yet despite the shift in role both her clients and colleagues sometimes asked her to utilise her personal lived experiences "*before they ask for the social work perspective*".

She also stated that 'expert by experience's and others with this "*combined*" experienced-based and professional competence often felt that they were "*between chairs*" in her words. This signified that both colleagues (experts by education) and service users were unsure of how they (employees with user experience) were placed in the overall system. This was quite a common theme in discussions I had with experience consultants and other 'experts by experience during fieldwork: many said that they ultimately felt that they fell *"between"* the roles of user, experience-based employee and a "*regular*" employee. When I brought up this common response with E., she argued that it was a symptom of stigma, both from external pressures and "self-stigmatising" that was difficult to avoid when the delineation between experience-based competence versus professional competence was made clear in her workplace. (I return to the issue of stigma in chapter 7).

Many working in the capacity of 'expert by education' may have had their own types of lived experience that are relevant to the mental health or substance context, while many 'service users' may have university degrees. Experience and life are, after all, complex and do not fit neatly into designated frames and binaries. Recognition of this fact can only be positive for the overall recovery perspective, certain recovery college participants argued. In studies on usage of experience and educative competence in the Norwegian context, 'experts by education' tend to describe themselves that they use only, or mainly, their theoretical and work experience as a resource (Klevan et al, 2018:41-42). They are also required to do so, in compliance with the EBP framework. Even for those working at the frontline of the mental health profession, for some it appears that their 'professional' job title is a barrier to being open about their own mental health challenges if experiencing such (Klevan et al., 2018:41-42). This appears to have negative consequences for the entirety of the field, including the progress of experience-based competence as a legitimate knowledge form. The different forms of competence are not mutually exclusive. As Klevan et al (2018:62-63) emphasises: "We stand in danger of locking both experience-based and theory-based professionals in one-dimensional roles and positions. An experience-based worker is not just an experience-based worker and a professional is not just a professional."

More on how competence is valued: The not-so-magical comorbidity/substance dependence background

During co-production settings and other initiatives that combine both education- and experience-based competencies, representatives of formerly marginalised groups may enter the health policy arena owing to specialised 'competence'. While individuals with experience-based competence can be employed in the health and social services without having a formal recognition of that competence, and are across Norway, different preparatory qualification programs exist, as already mentioned in chapter 4. Even with regards to the valuing of lived experience as a specific type of competency and one equal to that of professional competence (within certain settings), within the case study of the recovery college, certain types of lived experience itself seemed to be valued more highly than others by some actors, as we shall see in the following.

In one of my interviews, I asked O., an 'expert by education' about the experience of dealing with diverse competencies, both in terms of planning *with* (as in co-production, as discussed more in detail in the next chapter) and planning *for*. He remarked that it had sometimes been personally challenging for him that *"often, these experiences can be very*

different and have very different aspects," – by this, he referred to the differences especially present in how individuals have been involved '*in the system*' – as mental health service user, as substance addict, or a combination of the two.

It can be argued that this response exposes that certain types of lived experiences are seen to be more problematic and challenging for co-production settings and in general for the health sector, than others. Many individuals with comorbid disorders need to address both mental health and substance dependence challenges. Some of the recognised "flaws" in the structures and systems in place around these individuals may influenced and shape these negatively perceived occurrences (illegal acts, social isolation - cf. Landheim et. al, 2016). For example, in Norway, while both alcohol and other substance dependencies have been linked to negative social consequences such as unemployment, violence and social exclusion, misuse of alcohol, while legal, has been shown statistically to contribute more highly to health and social issues than illegal substances, according to a number of studies (Folkehelseinstituttet 2018, 103-104). For the purposes of cooperation between individuals with differing competencies, there is also a practical problem if substance use or comorbid health problems are to be a factor on which one's suitability for participating in co-production is determined, as statistics also show a very high percentage of comorbidity[16].

My informant, O., suggested that "*They that have the most – in a way – the most serious problems connected to double diagnosis are not always able to be [involved in] co-production. Very often are they so loaded with problems that they just survive from day to day, in a way."*

While this may be true for some, others argued that with respect to people with mixed backgrounds, one should not take it for granted that the 'seriousness' of one's past experiences may affect the ability to take partake in co-production and positively affect structural change, as those involved in co-production are generally accepted to have 'recovered' and are no longer service users in the same way as, for example, the target group for recovery college students.

Borg, Sjåfjell, Ogundipe & Bjørlykhaug's (2017) study of service users' responses to service employees with experience-based competence reflects that while in general, the service users experienced their interactions with 'experience workers' as positive on a variety of different levels, there were some occasions where this was not the case. For instance, when talking informally with informant O. ('expert by education') on this subject, she commented that she had had a similar experience with some recovery consultants. In her words: "*there are*

some who take as a starting point their own story and think that it can be completely generalised. That is difficult, because it is not necessarily [general].” Service users have in research studies described that the ‘experience workers’ were not always able to be attuned to service users’ situation - or were particularly adamant that the users should prioritise a particular method or lifestyle change in their recovery process because it was what they had done themselves. The researchers suggested that in some cases, those working on the basis of their experience may be still occupied to some degree with their own recovery process (Borg et al., 2017; Klevan et al., 2018), and in such cases may not have the distance that make them valuable in helping others in their recovery journey.

Recovery coproduced or opposed: perspectives from research

What distinguishes different perspectives on recovery – and those who promote and adhere to them? In this respect I will briefly present some of the *tendencies* that are recognised in recovery research. As was pointed out briefly in the theory chapter, recent recovery scholarship distinguishes between more classically defined clinical recovery (measured in terms of functioning or not functioning against a framework of clinical and often medical or symptom-focused markers), versus personal and social measures, as in Slade (2014:35-43). Lloyd, Waghorn & Williams (2008) argue that *the receivers* of mental health services tend to theorize recovery in terms of personal development, experiences and self-identified outcomes, whereas *service providers* (such as DPS in Norway[17]) in the position to implement standardized and ratified frameworks, procedures and evaluative measures as well as provide compassionate care, tend to lean more towards the clinical definition of recovery as defined by Lloyd et al. (2008) and Slade (2014:8-27). Medical interventions based on the ‘golden standard’ of double-blind experimental research designs increasingly gain terrain, as in clinical ‘evidence-based practice’ (EPB).

Simultaneously we find the emphasis on the promotion of the user voice and recovery-oriented services in policy documents and white papers as discussed in chapter four, and also an emphasis on personal and social recovery. Personal and social recovery is about the handling of the social consequences of mental health problems (“rehabilitation”), finding meaning in one’s chosen social and work environments, and contextualising the relationship of the recovering individual with their social environment, such as through education and work, economic situation, friends and other relationships (Borg et al., 2013:12-14). Schön et al. (2009) studied a number of individual recovery narratives about factors influencing recovery

and found that social relationships and connectivity, having a 'social life' was a key element in all of the factors present, with value placed on positive relationships with care providers, social and interpersonal relationships, and meaningful activities both inside and outside the home. They argued that the success of care interventions and measures, both by the healthcare system and by individual's social networks, should always be understood with regards to the quality and meaning of the individual's social life and relationships (Schön, 2009: 345). Sells et al. (2006) argued for the role of the wider social lives and networks in recovery through "community arenas", "meaningful activities" which assist dynamically in personal recovery through "a favourable redefinition of self" (Sells et al., 2006:15). Yates, Holmes and Priest (2011) argue that recovery should be understood ecologically, environmentally and socially rather than individualistically, focusing as well on the demonstrated link between social capital and mental health. They suggest that a limitation of many studies on recovery is that they do not sufficiently contextualise social, political and cultural systems, physical and geographic environments, economic climates, and so forth that can influence recovery, suggesting that focusing on the thoughts, feelings and interpretations of individuals in order to make them more 'positive' may not be as helpful as changing "toxic environments" (Yates, Holmes & Priest, 2011, see also Borg & Kristiansen, 2008:512-514).

Lloyd et al. (2008) advocate for careful usage of the term 'recovery' due to potentially conflicting definitions of the concept. They and Slade et al. (2014) advocate for professionals to move towards a reconceptualization of the recovery construct as one that can incorporate symptom remission, for example, along with user-driven and social perspectives (Lloyd et al., 2008). Lloyd et al. (2008) among others question the notion from clinical recovery measures that recovery is centrally about a return to the capabilities and functioning one had prior to the time of becoming "ill". Using the approach of clinical recovery as a reversion to the former state, the likelihood of actual recovery has been traditionally quite low for individuals with mental illness, however studies have shown that focusing on reformulation of individual identity away from the "sick" or "patient" identity and the former identities one has held, as well as accepting the role that illness has had or has in one's life, facilitates more effective overall recovery (Fernandez, Breen & Simpson., 2014; Davidson et al., 2005:481). They also utilise the concepts of responsibility and hope: recovery involving "…a process of moving from experiencing denial, despair and anguish to rebuilding hope, feeling motivation, and taking responsibility for one's actions" (Baxter & Diehl, 1998:349-355 in Fernandez et al., 2014:891). Other proponents of recovery and diversity take another radical approach, by

questioning whether illness is necessarily a catastrophe or a completely negative or life-changing experience for the individual (Slade, 2014:31-32). Peters & Besley (2014:110) argue that diversity approaches challenge the broader systemic exclusion and stigmatisation of vulnerable groups which is justified in social, political and cultural settings through otherness, whereby disability has become a "central cultural signifier of inferiority."

Summing up the chapter

Recovery scholars seeks to redirect the tendency among professional health providers to devaluate the knowledge born out of lived experience with recovering from mental illness and/or substance dependence by claiming that they possess 'competence by experience' which is complementary and of equal worth to that of 'competence by education.' This implies turning an individual from essentially a victim of their own experiences to an expert of their own experience, reasserting their agency over their own life. Recovery college models such as that of Nottingham seek to equalise the competencies of the traditional 'experts' and 'patients', referring to both as 'experts' – either 'experts by experience', or 'experts by education.' This is a radical step, looking to break down barriers and stigmatising factors by declaring that within the classroom, all are not only equal but also experts – recognised as being equally competent. All are on paper welcome despite the stark differences between other life factors as well as the types of experiences they have had, and all types of experiences and skills are relevant within the perimeters of that space. Bugard recovery college throughout its development sought to balance the 'competing competencies' within the classroom and the meeting room – both with regards to composition of the student body and the defined competencies of those in the research, development and teaching positions, in various ways. However, in my view, one should not underestimate the role of capital in Bourdieu's (2006) sense – social, cultural as well as economic – for how co-production between 'experts by experience' and 'experts by education' can play out in co-production settings, for example when discussing 'what is recovery' and what kind of recovery construct the college should be based on, and this regardless of the policy participants adhere to. The ways in which the different 'experts' can '…do things with words' (to paraphrase Austin 1975) - like that of the word 'magic' or technical terms - may bring barriers otherwise recognised outside of the "bracketed space" of the co-production settings of the recovery college into that setting. This although - according to 'experts by education' interviewed - co-production implies '*losing the* [professional] *label*' and start '*clean;*' disregarding official titles and be receptive and acknowledging of other experiences and competencies.

Husu (2013:272-273) argues that the framework of habitus and field is particularly appropriate for assessing the concept of individual and group competencies within different spheres, such as this thesis looks at. Pinxten and Lievens (2014:3-5) argue that these concepts are particularly useful in health research when used to examine the dynamic between social positioning and capital within fields, and how taste and embodied experiences may come to expression thereof in terms of lifestyle and health, along with service users' perceptions of their state of health. As Borg & Kristiansen (2008:512) argue, in the context of individuals with mental illness trying to integrate into the workforce, they often face an uphill battle or "lose the game before it starts" due to variety of structural factors and the role reversals implied. Discrimination and other societal responses to health issues such as mental illness and unemployment often focus on "changing the individual rather than removing societal barriers or finding ways to support individuals within their own contexts", which do not aid in holistic, contextually appropriate recovery efforts (Borg & Kristiansen, 2008:512-513). 'Taking responsibility' and 'harnessing one's own resources', I would argue, are important recovery-oriented principles that should always, however, be contextualised within the realities of lived situations. When considering differences in capital available to service users and service providers, for example, it is visible the asymmetry between such actors within the health field; asymmetries that the recovery college embarks on changing within the system itself.

Chapter six: Co-production within the recovery college

Introduction

As briefly outlined in chapter two, co-production was considered a key element to the radical recovery-oriented nature of the Bugard recovery college: a dynamic space where experts by experience would not only gain access to effect the project but were invaluable to the survival and success of the project. This chapter elaborates on co-production in situations in which major strategies and issues around the recovery college were debated. As will become evident in this chapter, discussions concerning co-production among the parties involved open up a range of issues that can be developed in terms of, e.g.; the relationship between education versus health/therapy; what recovery is (clinically, individually, socially) and what is considered crucial in order to recover (from the perspectives of service users, 'experts by education' and 'experts by experience'); what is "normal" and what is "deviant"; and so forth. These are huge issues, each deserving a thesis on their own. This chapter looks at some scenarios in which such important issues came to the forefront and were actualised and managed at different phases of the development of the Bugard recovery college.

Co-production; democracy and equality

During fieldwork, I experienced a variety of "official" situations in which the centrality of co-production to the recovery college project was presented by organisers to shifting interest groups and audiences. For example, co-production was introduced during one of the most integral moments in the recovery college's development that occurred at the start of my fieldwork, the "brainstorming" or idea collection event held at a local activity centre in March 2018, which was attended by a majority of service user or caregiver audience. Here is an excerpt from field notes:

> *The opening presentation of the event was quite grand and ritualistic, in similar bureaucratic style to some of the planning meetings, with the two 'experts by education' leading the opening speeches, the first introducing the second by first retelling his many achievements in the recovery arena to the audience, to applause. Then, co-production was introduced, explained as involving the meeting of the perspectives and inputs by "experts by experience", those with their own prior lived experience of mental health or substance issues and services and of recovery, and "experts by education", those individuals whose expertise within the field of recovery services comes from the more*

traditional outlets of education and work experience. Their equal value in co-production was to be enshrined at all levels of the Bugard recovery college's organization and in all activities in the making of the school - from the planning stage through until the execution and management of the school in its future. This also involved shared competence building between the parties on the way, and both parties were to be involved in the selection of ideas for development of and delivery (i.e. teaching) of the curriculum, which was the reason why the actual meeting was arranged. A key goal was also to have a diverse mix of competencies in terms of course receivership, as professionals and caregivers were encouraged to take part, not only service users, as students.

Whether on the meetings with the "project group," or during competency-building events, co-production was celebrated as a key equalising and also democratic strategy around which the recovery colleges evolved, and as the key element distinguishing the recovery college from other, non-coproduced or partially co-produced strategies (within other types of services offered to persons with mental health and subsistence dependency issues).

For one of my informants, R., the difference between the recovery college and other recovery-oriented services that utilise user involvement, is co-production and subsequent equalisation of competencies and roles. R. reflected on her first experiences with co-production from a study trip to Nottingham Recovery College:

> *What makes the recovery college special? Co-production - equality between those working on the course [referring to experts by experience and experts by education] and those attending [in the workroom and in the classroom]. The equalisation was what was most radical.* (Interviewee R., 'expert by education')

To quote one of the representatives from Nottingham during her introduction to the shared competency-building course held for those involved in the college:

> *We call them [the two competency groups] experts by expertise, and experts by experience, and we like to think of co-production as a democratic process between the two. [Co-production is] experts working together in a process of shared decision making. Co-production at the NRC is a model in which 'experts by education' work collaboratively with experts by experience with training qualifications, in co-producing*

a course through a scheme of work, if more than one session, with subsequent session plans as necessary. Each co-producer should have equally valued input into the decision-making process, course content and the production of the final documents.

The concept of "equalisation" and "democratic" as "special" in these citations also introduces the opposite; hierarchy, we may agree with Dumont (1970:20 in Bruun et. al., 2011:1): The asymmetrical (and according to the harmony model: complementary) relationships that traditionally prevail between teachers and students in the educational sector and between professionals by education and the service users in the health sector. As elaborated upon in chapter four, the health sector has traditionally been characterised by hierarchal relationships with those in need of professional services figuring "at the receiving end at the bottom," while those in the protected positions who possess this competence and deliver it, figures at various "levels" above.

Askheim (2017) suggests that co-production develops social and health care services through partnership on equal terms between those that provide and those that use them, which can also involve caregivers and families, voluntary organisations, and so forth. Askheim also distinguishes between the longer-established concept of *brukermedvirkning* (user involvement) versus co-production where the user has equally valid expertise and is as much involved in the production of services or goods in this context as all other parties, not merely 'consulted'. As seen in chapter four, *brukermedvirkning* has been a part of systemic change, including in the local context applicable to this study, for longer than the newer concept of co-production and its use within the recovery college context. Bøe (2016) argues that the nature of co-production may collide with the traditional hierarchical system of service provision, EBP (evidence-based practice) and New Public Management. Realising co-production still imply a serious re-evaluation of competencies and rearranging of attitudes and roles in this sector, and recovery scholars point at the need for culture change in the services (cf. chapter four).

Perceived challenges to co-production

During fieldwork, informants expressed different concerns as to whether the co-production strategy and goal would be achieved. Some feared that the equalising of competencies and associated rearrangement of roles might demotivate health professionals to engage fully with the recovery college. Expert by education H. expressed the following concern

regarding fellow 'experts by education' and their potential willingness to engage with the courses:

> *The biggest challenge was getting that diversity and the equality by getting the professionals to engage themselves with the courses ... It was a major challenge in Nottingham, and I see it for us as well – will professionals think they have any use of attending a course?* (Informant H., 'expert by education')

On the one hand, there was the worry of whether professionals would believe there was something to learn from a course coproduced by experience-based competency, and whether – after a lengthy education – professionals would consider it worthwhile. It was overall recognised that the professionals' engagement in co-production was equally crucial as that of those with lived experience. For the Bugard project, these concerns also attended to the composition of the student body, as they expressed not only wanting a diverse and balanced range of competencies in co-production and development but also during delivery, to ensure that the positive aspects of co-production also carried through to group work between students and so forth. Whereas H. worried about whether professionals would attend finished courses, informant F. in another interview ('expert by experience'), was principally concerned with whether experience-based competence and the 'user voice' would come through in the classroom setting:

> *The course is also strongly affected by how it is developed… through co-production with user representative… I think the biggest difference [in contrast to the other services available] is that there is now a voice coming in [in the deliverance of courses] that speaks the same language as those sitting in the lecture hall. I hope that we will use the "user voice language" – using simple Norwegian words, trying to avoid abbreviations. Mainly I hope that my voice and that of the other user representatives will come through….*

Later in the interview, F. also referred to one of the challenges in co-production regarding differences in what 'experts by experience' and 'by education' would consider crucial in order to create a course:

> *… some of the professionals, they are more concerned with course content – for example, with nutrition. I am more worried about – what does it do with you afterwards? They are more concerned with creating content and building courses, I am*

more concerned with… results. What does it do afterwards? We need both voices. (Interviewee F., 'expert by experience').

F. contrasts his (experience-based) perspective and performance (voice) with that of the professionals ("they"). Whereas the professionals are overly concerned with accuracy, terminology and theoretical outline, he (as an 'expert by experience') focuses on recovery effects and how the course may impact on the students' recovery process (*"results*"), while arguing overall for the presence of both in equal strength. F. also points towards the impact of coproducing the *deliverance* of a course (by two teachers; one being an 'expert by education', the other an 'expert by experience'), and the importance of recognition and identification across the otherwise teacher and students divide. Here he recognizes that 'experts by experience' may be more attuned to the life world of students (with own experiences within mental health and substance dependency issues). At other moments he also expressed that he believed 'experts by education' would be more concerned with how the project "*looks*" to the outside world and is received within the overall system (meeting deadlines, being attractive to potential students content-wise, attracting funding, not experiencing delays) whereas 'experts by experience' are interested in the impact on the personal and social recovery of students, regardless of how the college 'appears'.

Bureaucratic pressures and co-production: On recruitment, roles and tasks in the project phase

A number of factors may influence and sometimes constrain the ideal of co-production and equalisation of roles and tasks in the setting of the recovery college: such as the nature of the bureaucratic process, time pressure in which organisers rush to meet logistical requirements and experience the constraints of other, more vital work tasks; financing and issues with timetabling and payment. In the following, I will reflect on some challenges in this respect to realizing co-production.

As pointed out in previous chapter, the central board that steered the project development was composed of 'experts by education' employed municipally and in specialist health services, and 'experts by experience' also variously employed in the services. How the selection of this board at the outset took place is unclear to me, save for the principles of balance, diversity and mixed competencies. There was a focus at many meetings on safeguarding that 'the balance' between different competencies was as equal as possible for co-production purposes, for example in cases in which board members who were 'experts by

experience' were absent (recall that I was also asked to tape-record meetings in order to document co-production measures taken).

It was often apparent that college organisers were taking on a significant work load on top of their regular work tasks in order to keep the project going, especially in sometimes unpredictable circumstances. When going through minutes from meetings, it became evident that 'experts by education' carried out much of the planning and work load during the initial phases, solicited for money, planned the meetings, organised meetings, wrote minutes and organised events. Before a project leader was appointed in the course of 2018, an 'expert by education', de facto also served as the project leader. When the newly assigned project leader, an 'expert by experience', quit for reasons I am unaware after serving a rather short period, the former leader of the board took on the role of de facto project leader anew.

The impact of changing product plans and an "ad hoc" process

In the course of the project period between 2018-2019, there were some changes in the composition of the central board, for reasons I was not aware of, which contributed to an atmosphere reported by some as volatile and somewhat ad hoc. As was often commented during board meetings: "*This project develops as we go along,*" "*we figure it out later/as we go along".* The somewhat fluid project planning process did, according to some interviewees, have a bearing on how they themselves experienced the overall process and their own possibilities to influence what they were part of. For instance, it was argued by some that the call for planning meetings seemed first and foremost to have departed from openings in the meeting organisers' timetables. Again, from what I observed and overheard, key meeting organisers on the board also experienced difficulties with regards to getting feedback on proposals for scheduled meetings on email. There were often reflections of difficulties of communication from both key board members and those variably positioned in the wider reference committee and project group.

Some of my informants also pointed to a lack of preparation in due time before meetings started, something that left members waiting at times for up to half an hour. One explanation here is that the organisers who were directing the meetings, formulating the agendas and managing the minutes of the meetings were, as stated previously, taking on a heavy workload. Often, they came running from other meetings of a mandatory nature. Although personally very engaged with the project, organisers likely had to give priority to other tasks in their workday, making the recovery college project an extra challenge on top of a full schedule. This,

along with the changing nature of the board and committee throughout the life of the project, and some abrupt resignations, resulted in some board members taking on several different roles at once. While this ability to adapt reflects the degree of organisers' engagement in the recovery college, it may have also had the unintentional effect of giving certain board members indirectly more authority than others, effecting the balance of power, which can also have translated into co-production settings.

One example is that during the period between autumn 2018 and spring 2019, before the three courses were eventually developed and delivered, I observed as fieldworker that co-production and development for one of the courses in part occurred during meetings initially, before being shifted to its own development group after planners had had difficulties meeting deadlines and agreeing on the content of the course. Course ratification, as well, was completed at a meeting with a majority of 'experts by education' representation, whereby the first two courses were greenlit for delivery. Although there were two 'experts by experience' present at the ratification meeting, the approval process was arguably less equal than originally desired. This is not, I believe, a strategy for by-stepping co-production, but rather board members feeling pressed to provide completed courses and move the already delayed project forward.

What are the consequences of this way of working, and what is not necessarily considered by those in control? It would appear the duality of competence is sometimes exemplified further in these co-production attempts: those in more privileged positions attempt to make themselves more accessible and restructure the highly structured environment in order to positively influence co-production, which may have an equalising effect. However, in some cases this may only serve to highlight the structural differences between individuals, and that these differences may translate into the space of co-production settings.

The value of time: scheduling and contract issues

Ultimately the recovery college was developed through the combined efforts of not only the board and the designated co-production groups, but also the contributions of a wider group of individuals with a broad spectrum of competencies. A part of this work was in effect voluntary (although this was not planned for), at least not with respect to those engaged in the project who already figured on the payroll of the services. The majority of those in the recovery group were, or are, employed in some capacity in the health and social systems, municipally or

otherwise, but not all. Many who were employees were required to request time within their regular paid hours to use for the afore mentioned tasks.

"Time to do"

The challenge of finding time to work on the recovery college development, or as one of the representatives from Nottingham put it, "*time to do*", seemed to be felt strongly by some. Issues arose as some employees within the project group were only employed on a part-time basis and felt that they ended up contributing scores of "voluntary" work hours towards the college. Additionally, in part, to the structural hierarchy nature of the college's 'municipal parent' systems discussed previously, relationships between employees, employers and those in senior positions coordinating the college project complicated these matters further; Some employees reported that their individual managers were reluctant to allow them to use their working hours on the project, whereas others were given more flexibility. These concerns came to the fore occasionally. Most significantly, at a meeting I observed many involved in development tasks related that they experienced that they were devoting far more work to the development of the college than they felt they had been led to expect. One 'expert by experience', H., argued at the time, "*This takes a lot of time and energy, it is very requiring of us…"* This discussion was marked by a degree of tension in the room. It was argued then that everyone had been notified about the financial situation of the project and that development tasks had to be resolved within the amount of work hours that managers had allocated for this purpose. The majority of these were part-time employees and experts by experience. At the final meeting before summer breakup these concerns around payment and time at length were dealt with. It was stated that all research and development work, as well as teaching duties, would from the next semester's run be paid either by a separate salary agreement or via a predetermined contract with the employers of individuals already employed in a municipal/social work capacity.

Education or health? The desire to define what is a recovery college, and what is not, and the issue of legal requirements

A recurring theme across meetings and other events in project development was how the school should define itself – was it a health service, or an educational service/school? The college found itself in an unclear position, being linked to both health services, including the specialist health services, and other municipal services which cover a range of activities, including those intended to encourage recovery through education, work, and other meaningful activities. Following the Nottingham model was a key factor in the decision to ultimately define the

project as a ‘school’ and be as distinct from the health services as possible, despite the involvement variably of health professionals. A representative from Nottingham’s program stated during a competence-building course:

> *We classify ourselves a college, and we are not a health service, although we are funded by the NHS [National Health Services]. We don’t have nurses or other specialists on site… We also want students to feel as much like [this is] a regular college as possible.*

Nottingham recovery college did give priority to participant with an active service- user or caregiver status. When discussing recruitment to the courses, the representatives from Nottingham promoted “*openness and flexibility to students with a variety of different backgrounds,”* this although part of Nottingham’s requirements for application is that participants should be in some form for current mental health treatment or be a caregiver for someone undergoing the same (Nottingham Recovery College, 2019:7). Hence, Nottingham recovery college addresses active service users, but wishes to separate itself from the health services as much as possible. Similarly, many involved in the development of the Bugard recovery college expressed desires for a similar approach, whereby the association or link between specifically the health services would be minimal. Bugard appeared to want to go even one step further, by attempting to attract students with diverse backgrounds, including professional competence, and using personal interviews to ascertain suitability rather than requiring specific evidence of undergoing treatment, for example.

Differing viewpoints: combating stigma and the issue of logistics

During discussions at the board in Bugard, there was some disagreement about how removed the recovery college should be from the mental health services with regards to marketing and advertising of the new college. There were different considerations as to why the college courses should be identified as education rather than e.g. therapy:

> *We need to advertise this outside of the mental health services. We need to advertise as a part of the municipality – offer it to everyone. If we are too associated with mental health – then it’s not a course for everyone. As long as we are going to get rid of stigma, be for everyone – everyone who has something they want to ‘recover’ from.* (Informant P., ‘expert by education’)

Here is at once a recognition of the need to recruit widely in order to ascertain diversity of competencies and a hinting towards the recovery college's wider agenda of fighting stigma. This again implicitly recognises that there are potential stigmas attached to receiving mental health and substance dependence services, which again can hamper the wished-for diversity. Others again were concerned with the practicalities of logistics if recruiting too widely:

> *We're thinking that we will market this through the mental health services, place advertising around the mental health centres, as well as making a Facebook page. After a while we will have our own website, but we have to have a website that is connected to the municipality. The activity centres must market this actively, also NAV – but, right now we are a bit ambivalent, if we market too widely now, we will get a hundred responses to just two or three courses. So, we have to market a bit more carefully first.* (S, 'expert by education')

"Health path" or "school path": legal issues in relation to recovery issues

Legal issues were also part of the debate of whether the recovery college should be defined in terms of "education" or therapy": At the concluding meeting after the Bugard recovery college's first "semester", J. a board member ('expert by education'), went on to say that, with regards to the newly burgeoning recovery college 'scene' in Norway,

> *[As of now], in Nottingham's own words, there is nothing especially that we have in common with the others. At this stage, it is important to define what is it that makes a recovery college – and what is it not? It has become apparent that there are two paths that exist – the first, the health path, which means one must follow stricter guidelines and the law. The other, "school" path. Some of them are very similar to Bugard – on the "school path", whereas others find themselves more in the area of health, more similar to conversational therapy, using mainly the CHIME model of recovery. Bugard does, and will, define itself differently.*

If "the health path" was to be chosen, the informant contends, and the courses considered a form of therapy, serious restrictions and requirements would follow, having to do with whom may practice different forms of therapy within the health services according to law, issues regarding EBP requirements and so forth. Co-production could potentially be a difficult issue to tackle, when engaging experts without formal education. Others were less concerned with legal requirements if a "health path" was chosen and more concerned with how this

potentially would influence the recovery philosophy and the empowering aspect of the recovery college courses. When asking ‘expert by experience’ Å., whether he thought the services were by now as recovery-oriented as he and his colleagues could hope for, he stated:

> *Put simply, no. I believe the legal framework hinders the recovery perspective slightly… Among other things, without trying to speak for my colleagues – we "comfort", and "carry" – and we believe those are helping actions. A number of my colleagues are indeed educated to comfort and carry [referring to e.g. nurses] - that is what their jobs are about. We will comfort, carry, we will [ask the patients] – what is it you need? Meanwhile, the recovery philosophy as I see it is a bit more – what are you capable of? What resources do you have? And even though some of us have more resources than others… I find something, and – that I think you are capable of! Whilst some of my colleagues are a bit more scared to do so. We are scared for the taking of responsibility – that's also where the legal framework comes in – in case something happens. It's challenging, but I don't worry as much about the law (as they do) – I think, if I must stand up in court for (something that happens), I think I can bear it. They talk about – maybe I'll lose my licence – I can't lose my licence, I don't have a licence to lose, it's fine!* (Å., ‘expert by experience’)

K. recognises that ‘experts by education’ (‘they’) must abide to legal requirements if choosing "the health path" for the recovery college and why they may be reluctant to do so: If crossing into therapy without proper qualifications to do so, one may be "*sued*." The excerpt from the interview addresses broader issues such as "the learned helplessness" of patients as they are "helped" and "comforted" into helplessness by well-meaning health workers (Seligman, 1975), rather than challenged and empowered to use and find their own resources and capabilities, and take responsibility in the process of recovery, as ‘experts by experience’ such as K. felt should be emphasised.

The concerns raised recognise the difficulty of ‘picking a lane’ or the board members' need to define and set clear borders around what the recovery college would stand for and what kind of role it would take in an already diverse service environment.

Pros and cons regarding "the school path" – the experienced-based discussion

The issue of *formal recognition* of the Bugard recovery college as an educational program, along with the issue of formal requirements for being appointed as a teacher, were themes that to my knowledge were less discussed among board members – but were addressed among other

participants with experience-based backgrounds who wanted to know whether recovery courses students would receive formal recognition, something that might them to study further or more easily enter the labour market. (To my knowledge no one from the education department within the municipal services were invited in.) However, the board arranged for a course in health pedagogy in which the teacher role was discussed and other issues related to "the school path."

During co-production meetings there were those who expressed other concerns regarding 'the school path'. Many were worried about the recovery college becoming too "school-like":

> *The school shouldn't remind people of a real school or of their schooldays, back in the past. (Many have) painful feelings about school situations – homework, bullying, and so forth* (Comment from 'expert by experience' Ø. during discussion in plenum)

Others took a different approach: M., an 'expert by experience', remarked that while it was important to try to avoid these negative aspects, "*this was going to be a new type of school*" and it was important that the "*school focus*" be retained, feeling that this above all was the surest way to not cross the line into "*conversational therapy*". He went on to argue that:

> *It is very normal to experience things that are painful, to experience bullying, or such things, it is not necessarily devastating… What is important is and what we should begin with is: we have at least one thing in common, that we are humans, and we are there to learn and that is what is most important, not experiences, necessarily… We don't want to focus on painful things, only seek to normalise them… There should be a safety in being at the school, despite it being a 'school', it is important that everyone possible… is normalised.* (Informant M., 'expert by experience')

M. also remarked that with regards to some more typical relics of education, such as having a syllabus or a lot of extra assignments, *"we are not here to read through a syllabus or take exams. We are indeed here to learn from each other."*

The issue of 'normalising' raised by M. invites numerous questions and possible interpretations: Going back to school may be one important step in a recovery process, a step towards becoming part of "ordinary life" by way of "attending school" among other things for the sake of getting an education, a job etc. Those attending the school can also 'normalise'

themselves vis-à-vis others by saying that "I am a student" rather than "I am a patient/service user," the former option less tainted by stigma. Going back to school in a positive way could also psychologically speaking mean a step towards recovery in the sense of reducing the negative impact of past time school attendance and memories thereof; e.g. "normalising" them – seeing them in a different light and learning that one is not alone. By attending a different kind of school, but nonetheless a school, service users are normalised as "students" as against a service-receiving patient. M. emphasised that while the initial process may be uncomfortable, the benefits of 'going beyond one's comfort zone,' and without being 'comforted and carried,' were not to be overlooked.

What to co-produce? Individual/personal or social recovery focus in co-production settings

Another common discussion in co-production settings was whether, through course content and delivery, individual/personal (in the mind and the body) or social, community focused recovery (recovering in a recovery-friendly environment through active participation) should be the focus and how could both these aims be achieved? During the Nottingham course, these issues were debated both in plenum and in smaller groups and during breaks.

For instance, one of the participants with user experience, U., who regularly attended the project group's meetings, and who had for long been engaged as a volunteer in order to facilitate activities among service users, expressed expectations to find a much more *"doing"*-oriented rather than a theoretically- bent and individually-oriented school curriculum (such as mindfulness, nutrition etc.). From her experience, engaging in activities together with others, whether handicrafts, music or physical activity, and thereby increase the social network while learning a new skill or revitalising an existing one, is *"recovery in practice"* as she put it, in which recovery is also something happening socially. She mentioned for example gardening as a mindful and socially inclusive activity - and suggested the recovery college should facilitate that interested students could grow vegetables together and hence also meet others outside of the mental health field interested in such activities, perhaps, through facilitation of a local garden plot for the *"practice of mindfulness"*.[18] Others had ideas that with respect to physical activity, one could make use of the existing activity options locally, thereby increase social interaction and participation as part of the school curriculum. Many experts by experience I spoke with mentioned the role of physical activity in their own recovery journeys, either through participating in sport, taking a walk in the mountains nearby or training at a gym.

Some spoke enthusiastically about making training a larger focus of the municipal service offerings more generally.

Other co-production participants were more oriented towards learning about diagnosis and management of symptoms of for example depression, anxiety and psychosis. There were those who expressed a need to understand the language and reasoning of the 'experts by education' better. Those who were geared on therapeutic or more clinically inclined interpretations of recovery emphasised the role of the individual processes occurring within a specific person's mind and body, and in order to achieve this often focus on specific aspects of diagnosis or illness problematics. This implies a tendency to downplay environmental and social factors and their influence, and the issue of identity and belonging (Slade, 2016, 21-23). This interpretation suggests that recovery should come 'from the inside out' and prioritise individualised health goals versus goals that focus on the 'external', such as improving one's social network and gaining employment. The dynamic between the importance of 'inward-oriented', or individual-focused recovery – the individual's journey to self-improvement and self-discovery; versus societal or group-minded recovery is related to the broader discussion of stigmatisation and striving for normalcy, of which differing perspectives are also explored in more depth in chapter seven. Recovery, for many, means not just the former category of individual or internal recovery breakthroughs but moreover social rehabilitation, societal integration, belonging and finding meaning as part of a larger social network. Gaining access to normalised social fields though participation in work, education and other meaningful activities is known to be highly effective in improving individual perceptions of identity in recovery processes (Borg & Kristiansen, 2008).

Co-production of curriculum during the grand meeting of minds

In the following I present the co-production event in March 2018, in which around 25 persons with mixed competencies (experience-based in numerical majority) brainstormed suggestions for the recovery college's first courses. This event was celebrated among participants as exemplary of the spirit of co-production within Bugard recovery college. The meeting took place in a crowded activity house. After introductory speeches by some key board members (two 'experts by education' and one 'expert by experience'), the group separated into three smaller focus groups in order to brainstorm course ideas and decide on those that were most important. I had the opportunity to sit by one of these, which was made up of around 6-7 individuals with lived experience in some form (some were caregivers), and one of the key

board representatives ('expert by education') as facilitator. Although the groups were given quite a short time, around 15-20 minutes maximum, to produce ideas, an enthusiastic discussion was had about the ideas produced. Some examples of the coproduced course ideas were (translations from original Norwegian mine): *Mastering anger; Living well with psychosis; Introduction to recovery principles; Introduction to sharing lived experiences; Building positive relations; and Effective communication skills*; among others. The original pool of suggestions demonstrates a variety of interest fields from the user target group. While some respondents highlighted a desire to focus on individual-emphasised recovery goals such as "*Mastering anxiety*" or "*Journaling techniques for recovery*", many of the popular ideas highlighted common concerns around fostering social connectedness as a recovery method.

At the next project group meeting I attended after this event, also this time with participants with experience-based competence in majority, this 'idea collection method' was deemed to be effective and successful, the collection of ideas resulting from it celebrated as thoroughly coproduced, due to the high level of user involvement and a majority population within the overall group with some type of relevant experience. This was then distilled to the three most popular ideas, to become the first three courses to be developed/run and reflected the idea collection day. Participants expressed that they felt their ideas were genuinely listened to and valued by the 'experts by education' in that setting, and that their ideas translated into the courses that were eventually delivered.

Pedagogical methods: The development of the "turning point" (*vendepunkt*) method and "experience presentation" (*erfaringsinnlegg*)

In the following I explore at length certain pedagogical means discussed during shared competence-building courses. Special attention was paid to the issue of how to present and recount own experiences of recovery, which potentially is one of the important contributions of co-teachers who are 'experts by experience.' How the experience presentation should be best managed, as a central course component, was a key discussion during co-production competency-building courses (and later during the co-production of course content).

It was decided early in the development stages that the project groups (among whom figured those who would potentially be assigned to develop, and/or teach courses) and board members should partake in shared competence-building courses concerning such issues, one of which was a course in health pedagogy. Attendance overall at this course was significantly

higher from the service user and experience-based employees of the wider recovery college group than for other professionals (approximately half to three quarters).

Among other things, this three-day course which was designed to equip the college's teachers with the skills needed to lead a classroom, invited discussions about the relationship between educational and health-based perspectives in the recovery college, wider concepts around recovery and especially how to promote the 'user voice' in a variety of working environments. The audience raised questions such as: '*What if I am teaching a course where I did not have an experience that is relatable to the course itself*?'; '*How do I present my experience in a way that is helpful and not harmful?*'; '*How do I present my experience in a way that will not be negatively impactful for me?'; 'How do I keep the students' focus on the content and what I found helpful to me in my story, and not the bad aspects of my past?'*

The turning point method

Related to this, a teaching method known as the "turning point (Norwegian: *vendepunkt*) method" for use in the Bugard recovery college program was developed via co-production and enthusiastically agreed upon that it should be implemented in every following Bugard recovery college course. The turning point method sought to address many of the questions raised (see above), as a pedagogical aid to keep the students' focus on the importance of taking an active role in their own recovery, as well as reflect positive real-world experiences with the type of recovery competence being taught in that specific course (such as diet and physical exercise). It can be summed up effectively in a quote from ''expert by experience'' B. from one of the discussions from the course:

> *"It's important not to place too much focus on the past, but just state – how was it then – how is it today – and what changed?" The central focus is to be placed on the turning point or action, that the user themselves took actively, through their own agency, to aid them to the recovery journey from point A (how was it before in time, during the period of reduced capability or health) to point B (how they see their situation today, as in active recovery). The role of the individual's agency is key, as is the focus on the notion of a change being made, rather than overdramatising or oversimplifying events in the past that may have been difficult and traumatic, or overemphasising the positivity in the 'now.'* ('expert by experience' and reference group member B.)

To further illustrate, here is a quote from recovery college teacher L.:

> *[In the course I teach] I use my lived experiences of having used activity and diet as turning point. I always say it is important to use my experience actively. I had a turning point when I realised what physical activity does for my mental health. When I had prolonged enough my physical activity and set it into a system, logged some things, then I became interested in that maybe I need to do something about my diet. That became a new turning point… I cannot document it… But I can prove that it is how it is, on my own body.*

L's recollection shows that the significant event was not a random occurrence giving some kind of 'jolt' to the system and setting her on her recovery path, but a result of actions and decisions undertaken with full agency, the importance of which she herself recognises. During the course in health pedagogy, she described it further by drawing an arrow on the whiteboard, and sweeping her hand in a forward motion, encouraging us to focus on the element of change: *"we don't focus on how it has been, but rather the turning point that ensured today, as it is, could be like this, or could be better."* The turning point method was coproduced and agreed upon to be used as part of the wider '*experience presentation*' (*erfaringsinnlegg*) concept, a tool which inspired lengthy discussions during the course in health pedagogy (and later also during the Nottingham course presentations from Nottingham's representatives).

The kinds of discussions and concerns related by students as above reflect the inherent complexities of developing competence via experiences, memories or knowledge that is generally held to be tacit and held in the body, as defined by Adloff et al. (2015:7-10). It would also seem that transforming such experiences into transmissible or teachable knowledge arises in a variety of complications, it is not as simple as just telling a story from one's past. This presents a compelling argument for the equal weighting and value of experience-based competencies and knowledge development with other competencies.

The Nottingham course and "the experience presentation"

How to present own recovery experiences for educational purposes also became a topic during the 'Nottingham course,' which was held later during autumn 2018. Some 'experts by experience' reflected on how they might give a presentation alone, at the start of a new course, using 'the turning point method.' Other ideas included take the form of an interview or 'role

play' between the two teachers, who would practice beforehand where possible, whereby one would relay the 'experience', aided by questions from the other. (This is similar to the use of turning points in qualitative interviewing, specifically narrative life histories (Arvidsson, 1998:61, in Ytrehus, 2004: 27).

During a discussion in plenum, a peer trainer (course teacher) from Nottingham Recovery College reflected on the suggested "turning point method." She related that they did not use a specific pedagogical aid such as this in the Nottingham recovery college: She used her experience *"when it was natural to do so"* and urged those becoming course teachers to consider *"using an experience that is maybe a five or a six, not a nine or ten"* on a scale from zero to ten in terms of emotional content, 'triggering effect' or otherwise containing negative experiential aspects. It became clear that the Nottingham recovery college did not give priority to a specific pedagogical aid with respect to 'experience presentation,' save for evaluating degree of emotional control and impact.

The demise of the turning point method

Overall, the turning point method can be reasonably argued to be a genuinely coproduced teaching method. But was it successfully followed through? Even when co-production tools such as verification criteria and burden of proof are put into place, can the viability of 'the user voice,' as reflected in such methods, always be guaranteed? Unfortunately for this method, it became watered out over the course of the college's development. One reason may be that the municipality's focus on the Nottingham model appeared to be paramount, such as the afore mentioned peer trainer's recommendations to use a more discretion and feeling-based approach, using experience-based stories when it was "*natural*" to do so rather than introducing specific frames. Maybe the 'experts by experience' who initially celebrated 'the turning point method' found the Nottingham feeling-based method as satisfying and went with it. In my opinion, though, the Nottingham approach was given more airtime than the turning point-approach, which was brought up but then appeared to be somewhat silenced. This 'silencing' can be reflective of conflicting interests or time pressures, rather than any ulterior motive by any representative, and these interactions are difficult to analyse more deeply given the wide possibility of interpretation. However, it does seem to speak to a preference for the already agreed upon (by the board) Nottingham model, this coming from above.

During co-production meetings as part of my participatory action research, I brought up the notion of the turning point method on more than one occasion, as I had seen little to no

evidence of it being used in any other college work since its original inception. Again, this was put aside, or after a short discussion we were asked to bring the focus back to the theoretical content of the course rather than the structure of the experience presentation. From what I know, the method itself has not disappeared completely, and although not systemically put to practice, it may have influenced how co-teachers present their own experiences.

Assessing the questionnaire

After the case study had 'run its course' I was given access by board members to thirty-four feedback sheets from the students who had attended each of the first three courses to revise the responses. I was unable to attend a course in person but had spent sixty hours co-producing one of them, hence I was also personally interested in the feedback, and not merely as a fieldworker. A thorough analysis of the data was not yet available at the time of writing, according to my contacts at the recovery college. I was, however, allowed to look through the feedback sheets. Analysing them is not overly necessary for my own data, considering this thesis is qualitative in nature. Nonetheless, with reservations regarding the criteria for assessing validity and reliability in quantitative research (cf. Cresswell & Cresswell, 2018), I will briefly point at possible implications for evaluation of the success of the recovery college. These I draw from my own simple statistics and the qualitative responses added to the feedback sheets[19].

Forty-five students in total commenced in the college's opening run. The majority completed their chosen course, and thirty-six students responded via feedback sheets. The anonymous survey format is coproduced and borrows heavily from that of Nottingham Recovery College, with five focus areas related to various aspects of the experience of attending, the content of the course and the experience of co-production.

Those answering were asked to mark the degree to which they agreed or disagreed with the listed statements, such as "Did the college provide a warm and welcoming reception?" The overwhelming majority of the response sheets, it was clear after a cursory glance, marked all responses between neutral to above the neutral marker (agree, or strongly agree). Overall, the majority recovery college students from the first semester self-reported that they felt a positive increase in their own competence level after attending a course. Course number one, which was four weeks in length, appeared to have the most neutral to positive feedback from respondents as well as a high self-assessed increase in competence: 89% report increase in competence and have a positive response. Course two, over six weeks, reported 69% increase in competence and an overall positive response of 70%. Course three on reported 58% increase

in competence. This course, which was two weeks in length, received the least positive responses as shown, however approximately 64% of the students appeared to be satisfied with the overall course.

Qualitative responses

For each of the courses, there were several responses as to course length, and it appears that longer course times were desirable for many, especially in the two and four week courses where there were many responses as to how longer course times would allow for more practical application (for example, more time to work on specific methods taught in that course, or apply newly gained skills in real-life settings such as on a group excursion).

Several respondents reported satisfaction with the learning environment and social possibilities the college gave room for, reported that they chose the course for social reasons and to meet others, and most reported feeling welcome and safe in the learning environment, although there were several comments as to unsuitability of the college's location, suggesting that it was difficult to socialise due to the lack of a common area and coffee facilities et cetera. Generally, students seemed to respond positively to the coproduced content in each course and the experience of co-production in the classroom setting, reporting positive social experiences and group-focused learning. There also seemed to be a general desire for longer and more involved courses, suggesting that the courses were not too challenging or difficult for the target group. Many said that they would take the methods they had learned for various 'recovery skills' further in their daily life, hence suggesting potential for increasing overall recovery capital of the course attendees, as well as social capital due to increased positive interactions with other individuals and the sense of commonality.

One of the board members mentioned to me that many people placed their names on their response sheet although they were advised not to (and there was no section given for a name on the sheet to prevent this), because they in her words "wanted to show that this [the recovery college and my experience of it], I stand behind."

According to my brief analysis less than 7% of respondents provided any responses in 'disagree' or 'strongly disagree' columns. Of these sheets as well, most responses were overall positive, and in terms of how they seemed to have experienced the course, this cohort reported overall "feeling welcomed as a student." An even smaller percentage only seemed markedly dissatisfied with the content of course, stating that "they felt welcomed and that the

environment was a positive one," however they felt they did not receive any useful information or improved their learning in any way or their capacity to "live better".

Summing up this chapter

This chapter has highlighted the overall coproduced character of the recovery college and some of the issues under debate along the way, along with some of the constraints put on co-production owing to bureaucratic, legal and other impediments. By choosing the Nottingham model, including working along the lines of the material made available by Nottingham recovery college ("Recovery in a box"), co-production has taken place basically within the frames of this model. This is probably the reason why coproduced elements such as "the turning point method" did not find its way into the coproduced courses. During 2019, the three courses received an overall positive reception.

Chapter seven: On co-production and stigma

Introduction

The recovery philosophy that the Bugard recovery college adheres to seeks to counteract processes of stigmatisation both at a system level, organisational level and interpersonally. Co-production is one of the main strategies employed against organisational and interpersonal stigma. Co-production, as discussed in previous chapters, involves diverse competencies meeting on 'equal footing,' complementing each other. It can also be interpreted as a deliberate meeting of Goffman's "mixed contacts"; whereby stigmatised and non-stigmatised individuals in a social setting, will in many cases make the "stigmatised" feel unsure of their position and themselves in a way the others do not (Perry, Gawel and Gibbon, 1956:, in Goffman, 1963:7). Throughout my fieldwork, stigma or discrimination was often more indirectly referred to, although some of my informants also used a term such as "self-stigmatising" in interviews. As we have already seen, one interviewee, A., (in chapter 6) argued that marketing the college outside mental health services was crucial because of the increased likelihood of reaching potential students, in addition to *"removing stigma"*. For A., the college needed to be able to reach absolutely everyone who might be interested, not only those who were in active treatment (such as in Nottingham's case), would be a radical step for de-stigmatisation. Bugard's concern with having a diverse mix of competencies, including taking steps in student allocation methods also seems to reflect the overall concern of removing stigma. The 'magic' removal of asymmetrical relations within the hierarchical workplace culture of the municipality also speaks to removal of stigma through removal of label and role: individuals are not only taking on new roles or challenging expectations of what the role of 'expert by experience' may entail, but in certain situations can all roles said to be potentially *removed*.

Gullslet et al. (2014) found that Scandinavians with mental health or substance use challenges experienced both "self-labelling" and "labelling by others" as having a detrimental effect on social life and in various settings, which overall impacted on their ability to recover. As detailed in the theory chapter, stigma is a complicated social process. Stigma can be reflected through and viewed at different levels of analysis, for example, the feeling of inferiority and insecurity over one's experience with mental health issues in a workplace setting; the lack of opportunities for advancement for an individual with a history of mental health difficulties; the association of certain individuals with criminal activities in the minds of officials.

In the following I explore a series of cases which all point in the direction of perceived or experienced stigma brought into co-production settings and work places – this although I hasten to add that in fieldwork settings I found the atmosphere overall to be generally neutral or positive towards various competencies and experiences and respectful of the issues at play regarding mental illness and substance dependence.

"They doubt my experience"

In a personal interview with S., an 'expert by experience', he began talking about some of the challenges involved in coproducing recovery-oriented services. He also mentioned that it was often challenging being the only employee with experience-based background among educated professionals in certain workplace settings. He lowered his voice (although we were alone), saying:

> *"What I think is most difficult about that is… they [other employees] doubt my experience. Right? It is my experience that suddenly [if bringing in his own competence] has a question mark. Then it would have been good to be two… To manage that alone, can be difficult,"* he continued.

S. almost whispered when articulating that "*they doubt my experience,*" as if someone was listening or as if telling a secret, or something that was difficult to express. One of the implications here is that while S.'s colleagues do not necessarily (or at all) doubt the relevance of S.'s experiences, nor the relevance of it in their workplace, nor the validity of it as a form of competence complementary to their own, S. nonetheless suspects it. S.'s comments maybe reflect a sense that his former experiences and the stigma attached to them in some way still affect the ways in which he is able to utilise that experience in the workplace. The influence of stigma around the experience in the past may then make utilising experience-based competence a double-edged sword in reality. S.'s caution in relating this to me as though sharing a difficult or personal secret may reflect a feeling of self-stigma and the "insecurity of mixed contacts" when in settings with co-workers who, in some way are suspected of either directly or indirectly to place doubt on the validity of his experience (Goffman, 1963:7).

S. may also have been experiencing a conflict around an element of his "virtual social identity" (Goffman, 1963:7) in terms of himself as an employee without formal education, working on pair with educated health workers, and simultaneously recognizing himself as, among other things, his former role as a service user. This interpretation is motivated by the

fact that during fieldwork, there were others who related that in the past, they had been met with comments such as '*So you did not have to undergo a lengthy and expensive education in order to work in the services?*' when beginning to work as 'experience consultant' some two decades back in time. Such comments were experienced as stigmatising and hurtful, according to those who told of such occasions.

Whereas such comments in the past clearly expressed negative attitudes, it can also reflect other issues such as resistance towards policy implementations from above (Askheim 2016), and the issue of competition in the local workplace and profession strife: It is not necessarily so that the employees making such comments back in time set out to say hurt and say something blatantly stigmatising about those with lived experience now working (maybe even where they once were patients), but rather this can reflect perhaps an "unthinking" (Goffman, 1963:7) in Goffman's terms, maybe reflecting e.g. fear of devaluation of own work in a situation of competition in the workplace regarding 'who can perform which tasks', as mentioned in chapter four. Nonetheless, the effects upon those receiving the comments would come down to the same. When informants recalled such comments, they argued in contrary to such arguments that they had undertaken the hardest education of them all, through their lived experiences.

Among the absolute majority of the 'experience consultants' I spoke with during fieldwork around issues such as stigma (at least 15 persons), they reported that this was mostly a thing of the past and very rarely would experience consultants nowadays receive derogatory remarks, rather it was held to be the other way around: They were cherished for bringing hope of recovery to both service users and to employees, as they themselves exemplified that recovery is within reach.

Time politics and the 'illness' argument

Other issues related to that of being employed as an 'experience consultant' in the services and engaging with e.g. the recovery college, were hotly debated during my fieldwork. When interviewing E., she was upset owing to what she termed the municipal '*time politics*' She said both herself and a number of her colleagues had been rebuffed numerous times when asking about possibilities for full-time employment, receiving answers that she felt were *"discriminatory – as though they think I will not be able to handle being employed full-time because of my background."* She argued that this was related to another common problem: *"the sick argument"*. Experts by experience such as herself, she said, were wary of using sick

leave entitlements because they felt that their taking personal leave would be interpreted as *"something to do with their condition"*, even if it was for a banal cause such as a cold. Any type of employee "*could suddenly develop cancer and need sick leave*", she said, yet experts by experience would be judged differently for exhibiting signs of illness or weakness than other employees. She felt the *"sick argument"* was used as a direct justification as to why employing relatively few experts by experience were employed fulltime:

> *"Recently [in one of the departments], they advertised for and hired a number of full-time [non-experience based municipal] employees, and two experience consultants for part-time positions. If they had the opportunity to hire several full-time positions then, I don't know why some of those couldn't have been more 'expert by experience' positions, or rather hire one full-time 'expert by experience' than split the role into two part-time positions. We can't live on a part-time wage any better than a 'normal' employee… It is just as hard for us. Full-time employment should be the goal."* (Informant E., 'expert by experience').

While similar experiences to E.'s were echoed often by various experts by experience I spoke with during fieldwork, others felt these claims were perhaps exaggerated. One 'expert by experience', G., was particularly decided in an informal interview that she had not experienced any types of discriminatory behaviour and had not found her experience to be any different than "*a regular job position, a regular workplace.*" She wanted to show through her role, she said "*that it is possible to be completely healthy, and have a normal job and a normal life, regardless of how hard life has been earlier.*" For G., the successful attainment of 'normalcy' in this way was indeed a measure of successful recovery.

In other conversations, there were some participants were adamant at they received, on the whole, the same work tasks as all others in equivalent positions, but were frustrated at the lack of full-time or promotion activities for those who desired them, commenting that overall there was a tendency to assume that experts by experience either *"couldn't handle"* or would not desire the responsibility of a fulltime position. G., however, did have a full-time position as an 'expert by experience'. She also stated that for her, gaining fulltime employment had not been difficult, and that *"the opportunities are there for those who want them"*.

"A better person"

During the week-long course held in Bugard by representatives of Nottingham Recovery College, much of one day was devoted to how courses should be verified as adequately

coproduced, recovery-focused and 'ready for delivery'. Early in the day, they instructed us to brainstorm in groups of three or four what types of principles we thought were key to define a course as appropriately 'recovery-focused'. I was seated in between a professional who had for long worked in the specialist health services and a user representative who had not yet accomplished an MB-education but was applying. First, we sought to clarify what was meant by recovering. The professional took the lead, remarking:

"*Well of course – it [recovery] is about becoming a better person*."

The user representative responded immediately by saying rather curtly,

"*A better person – that's just wrong*"

Looking rather taken aback by the user representative's response, the mental health professional tempered the initial statement by saying it was a "*better life*" or "*better standard of living*."

In the following workshop situation, there was a degree of tension amongst the work group after that initial statement. Shortly after, we reconvened with the main group, so the discussion could not continue.

It is possible to interpret this exchange in different ways: Did the professional mean that recovery should be about *feeling* better within one's self identity and feeling like one has a meaningful place in the world, or did the professional intend that recovery should be about a progression from a less-desirable state to a more-desirable state in the eyes of society? When the professional says *"a better person"* this could be read from the perspective of the service user with whom the professional interacted as evidence of a stigmatising attitude towards those in recovery, suggesting they need to become "better" or that they are, essentially, in some way, incomplete before they have recovered. Again, this interpretation– which I believe is representative of how the user representative interpreted the professional's statement - may reflect as much the user representative's own self-stigmatisation that so to say reacts to the professional's statement; this may reflect attitudes, expectations and even prejudices towards professionals in the services born out of negative experiences as a service user with stigmatisation. I may add that having interacted with both the professional and the service user in other fieldwork settings, I believe both would hold that a recovering individual would gain

a "better" self-image, and become happier and feel more contented, rather than meaning to suggest a moral failing within recovering individuals generally.

Simplifying versus problematising: recovery jargon and language as an indicator of co-production

It is also possible that the professional's phrasing of recovery in terms of "*becoming a better person*" exemplifies an attempt to 'simplify' her own technical, or profession-based understanding of recovery, possibly due to a belief that I myself (younger and still a student), or user representative (experience-based competence role), or both, would have problems understanding what she meant, or that she would 'come off' as too technical. The awkwardness of the overall exchange suggests that the transition to a different "competence language" was perhaps not altogether smooth. One can speculate whether the user representative's response may be a result of feeling 'spoken down to'; reacting to a perceived negative and/or stigmatising attitude present in the professional's statement. Language and terminology were a wider issue among recovery college participants in coproducing settings in Bugard, as noted in chapter five.

"Exposing themselves": stigma and visibility

In this excerpt, 'expert by education' T. reflects upon perceived challenges with respect to co-production situations, which for her revolved around difficulties working with individuals with diverse backgrounds, especially when that background involved substance abuse.

> *"There are many who have been in the co-production context where people have different backgrounds, different treatments, some [experiences] primarily from their drug experiences, some primarily from mental health problems. For me, it has been challenging… because they who have been involved in drugs have often been involved in criminal activity – they have used drugs illegally and, in a way, have … exposed themselves [negatively] in the public space while many with mental health problems have tended to hide themselves. [However] there are many that have both issues simultaneously [and] the substance and mental health services are very interrelated. So, it makes sense to have them together."*

The crucial issue here is the expressed unease regarding those who have potentially "*been involved with drugs have often been involved in criminal activity*" and now may enter co-production situations. This excerpt may "unthinkingly" (Goffman, 1963:7) or subtly express negative attitudes related to the issue of the visibility of substance abuse, such as in the "open

drug environments," which were covered in chapter 2 briefly. In contrast to the mentally ill who "hide" themselves, the open exposure of one's addiction presents indeed a "challenge" for the mental health and drug services, as T. says. The individual with mental health problems is painted as quieter, less visible, "hidden" from wider view (and hence not disturbing the normal social order), in potential opposition to the individuals who "expose" themselves on open drug scenes downtown and involve themselves in criminalised activity that breaks with the law and otherwise social order, implied as a result of or in relation to their substance dependence issues. Douglas suggests that actions that make issues such as mental illness or drug addiction visible, invokes negative reactions due to them being "formally classified as abnormal" (Douglas, 1966: 98). They are, as Douglas (1966:33-36) described it, "matter out of place", visible signs of social dysfunction and systemic disorder, which carries an inherent risk of "pollution" or contamination for those within the "normal" social barriers, and provoking reactions of maybe fear or concern. In a sense, those who openly expose their dependency issues do not even seem to try to avoid being stigmatised. Professionals working within the contexts of mental health and substance dependence are well aware of the connection between substance dependence disorders and mental illness disorders (Landheim et al., 2016:34-35) However, the challenge is also about the visibility of societal dysfunction and the association of the wider public of lack of services, for example, with the 'performative' nature of open illegal substance use.

"I will always be an addict"

During the course on building a recovery college with Nottingham representatives, there was a discussion about establishing a *"classroom agreement"* at the beginning of each course. The teacher representative from Nottingham suggested that to save time, it was useful to develop a general agreement or set of rules and expectations (such as coming on time to class) during one of the first courses which could then be brought into each course and then co-produced to suit that class, via student-led discussion. Nottingham representative N. clarified that this agreement was separate to the overall rules of being on college grounds, one of which was *"being sober and not consuming anything on the premises."* During the break after this session, I observed a discussion in a small group of around 5-6 individuals in total sitting at a table, some of whom were experts by experience, others, profession, including the two representatives from Nottingham, about this particular rule. N. reiterated that being *"using anything"* would be viewed by Nottingham staff as a serious rule breach. Norwegian 'expert by experience' M. questioned how this would work for opioid maintenance therapy users, emphasising became enthusiastic about the fact that using opioid maintenance therapy as part

of one's recovery should not bar otherwise able students from attending the college. M. responded by saying explain that he had used opioid therapy as part of his own recovery, stating decisively, *"I will call myself an addict… I am not afraid to say I am an addict – and I will always be an addict!"* The response from the others at the table was mostly stunned silence.

M's emphatic assertion that *"I am, and I will always be an addict,"* stuck in my mind the rest of the course. It stood out in stark contrast to the atmosphere of carefully placed language around stories and experiences from recovery, of being cautious not to "trigger" fellow students with language or retellings that were too 'extreme', and the focus on the recovery portion of one's life, the 'hard times' being in a sense, in the past. M.'s assertion spoke loudly of the fact that for many, even those in the same room as us, recovery was still happening – it was not a dichotomous process, but an ongoing transition. Moreover, the manner and decisiveness of M.'s declaration showed something else: a sense of pride, empowerment and possible 'reclaiming' of the *"addict"* label, and refutation of the expectations and rules around sobriety and within the recovery college context. This exchange may also reflect conflicting ideals around what it means to recover – does it entail complete sobriety and abstinence as the end goal? Research on opioid maintenance therapy has shown that it is often key in assisting individuals to participate in other recovery-focused activities and function normally in daily life, and many will realistically require these aids long-term (National Institute on subsistence dependency 2018). As in the previous excerpt, where T. found it more challenging to work alongside former substance-related service users than former mental health service users and appeared to find the visibility and presence of their 'problem' more confronting, such attitudes about opioid maintenance therapy as a less legitimate 'aid' to recovery may serve to entrench stigma and misunderstanding around certain conditions. Use of antidepressants or other medications for mental illness would arguably not be discussed as potentially violating recovery college rules.

"I refuse to be called a user"

It is interesting to compare M.'s assertive self-definition as *"addict"* with a comment made by interviewee L., in an interview, about the negative side effects of stigma that came along with using a recovery-oriented service (in this case, it was a local activity centre):

> *"The main problem with using a centre, or being involved with it… You get labelled as a user, and I was never a user. I was merely unemployed"*

Despite having been involved with other “users” in her experience at an activity centre, L. rejected the label *“user”* for herself, suggesting that it did not fit her due to her being unemployed, not (by implication) mentally ill or substance using. An assertion such as this makes visible the inherent negative connotations of being a “user” for an individual such as L., who feels she does not belong in that category. The excerpt above with M. on the other hand, seems to reflect a very different attitude. M. appears, at least, in to have taken the *“addict”* label, a stigmatised and loaded label, and embraced it. In doing so, he demonstrates agency and acceptance and a sense of positivity or empowerment about a formerly negative label.

Brontsema (2004:10) argues that reclamation of words that are derogatory in origin such as “queer” and “nigger” which have since been repurposed by communities they were once used as epithets to subordinate cannot remove the stigma and pejorative nature of such words completely, but rather their reclamation and usage highlights and subverts the stigma behind the epithet. Rather than seeking to neutralise the negative value of a derogatory term or change its meaning entirely, the act of what Brontsema (2004:10) terms “stigma exploitation” transforms the “tool” of stigma into a “sign” of stigmatisation, and in doing so highlight the social constructs at play, as the reclamation of “queer” can challenge the construct of ‘normal’ sexuality. While informant L. rejects the term “*user*” entirely, refusing to engage in neutralisation or reclamation, M. takes another quite ‘loaded’ epithet and embraces it, giving possibility for a more nuanced frame of the “*addict*” whereby both the visibly wretched and stigmatised character that indulges in criminal behaviour and exposes themselves without a care for social norms, as T.’s reflection earlier is reminiscent of, *and* the changed, accepting, individual in recovery (whatever that means for them) can exist simultaneously. Making a statement such as this – and doing so boldly within the physical structure of the municipal hierarchy, shines a light on the stigma inherent in N.’s (superficially quite banal) statement that sobriety is an expected part of normalcy and a characteristic that needs to be fulfilled to gain access to the normal society via the recovery college. Alternatively, in Slade (2014:30-32), the diversity model of disability attempts to show that mental illness is not wholly negative or dichotomous (whereby individuals are clearly categorizable into mentally ill or normal, sober or addicted). Slade (2014:30.32) also cites the more recent tendency for successful or popular figures such as celebrities to be open about their own experiences, displaying that normative markers of success or a “good life”, artistic or other meaningful achievements and mental illness are not mutually exclusive. When viewed through this lens, L.’s perspective that *“I am not a user – merely unemployed”*, while possibly inherently self-stigmatising in its acceptance

that a *user* is a wholly negative label put on those attending the activity centre by those outside that environment, also suggests that being "*unemployed*" is not a label worthy of stigma. Her almost nonchalance with being "*merely"* unemployed suggests that her status as unemployed does not bother her – a radical stance in a society that suggests employment should be the ultimate end goal and marker of success, including in recovery.

Summing up this chapter

My main argument throughout this chapter and what I have attempted to show is – stigma is complicated, stigma is nuanced, and the 'self-management work' of stigma that many individuals have taken on when they were stigmatised by others on prior occasions may carry through in various co-production settings, although not intended by any of the parties involved. The aim of this chapter has not in any way been to demonise individual interactions, rather to discuss how stigma can be more subtly expressed, and how attitudes and reflections affected by stigma around mental illness, particularly with regards to self-stigma, are reflected in the discourses I observed. One insight is also that although challenging, it can nonetheless be easier for 'experts by education' to let go of professional roles in co-production settings than for 'experts by experience' to rid themselves of expectations regarding stigma in 'mixed contact' situations.

Chapter eight: coproducing societal integration

Introduction

This chapter highlights wider issues regarding how the recovery college fits with multidimensional national and municipal governing strategies concerning integration and future directions in health care/social welfare. I ask: How is co-production within the frame of the recovery college seen to facilitate societal integration of people with recognised disadvantages, relative to other strategies?

On co-production and the welfare state in Norway

Askheim (2016:25) critically assesses the concept of co-production that saw a major breakthrough in Norwegian welfare politics, such as via the "Innovation in care" policy (Helse- og omsorgsdepartementet, 2011), but was also introduced via health reform policies implemented during the 1990s, by the emphasis put on user participation, partnership and collaboration between caregivers and service users in various white papers (see chapter four). Public health and social welfare reforms in the 1990s recognised that hierarchical designs of mental health services inherited from the past were ineffective in promoting recovery for patients and for reintegrating them in overall society. At first, NPM reforms were launched for the sake of increasing the effectivity of the bureaucratic and health care operations, however, the recognized negative effects of NPM reforms within health care increasingly came under pressure (cf. Debesay et. al,. 2014). Under "Innovation in care" (Helse- og omsorgsdepartementet, 2011), co-production is portrayed as the major strategy by which better quality services can be produced and tailored to the individual and the local context in an ever more individualized society (Askheim 2016:26). Co-production also reflects a democratic agenda, for example in the sense that diverse competencies are recognised as valuable, not simply that of 'experts by education', but also that of 'service users' and other non-professional actors. Co-production is overall celebrated in white papers as the method by which the challenges to the Norwegian welfare system shall be met for the future, in which not solely the health and social services must contribute but also civil society actors such as voluntary organizations, family and other networks, and so forth. According to Ostrom (2012:xv in Askheim, 2016:28):

> This…marks the beginning of a new era when co-production is viewed as an important process that can increase the benefits to citizens as well as public officials trying to improve the quality of public services without major increases in costs.

The process of 'opening up' welfare production to actors other than public services, also promises to put the brakes on public expenditures in the age of neoliberal policies. According to Askheim (2016:25),

> …Economic reasoning is linked to co-production. The major challenges the welfare state faces in the future, necessitates new thinking and that actors other than the public health and social services participate in welfare production. (Translation mine).

Askheim (2016:34) critically assesses whether co-production – and the harmony model of democratization and partnership upon which it rests – may disguise some of the challenges involved in co-production, for instance, discrepant values and motives among the parties involved, asymmetries in relationships, and the issue of power that may translate into the co-production setting. Co-production is principally introduced from above by governing bodies, and according to research cited (Voorberg et al. 2014 in Askheim 2016:34), co-production settings have to little extent been explored empirically but is rather treated as a goal in itself, and as an ideological, communitarian -bent construct. Moreover,

> Co-production and co-operation can therefore also primarily be seen as symbolic processes for promoting normative integration between central and dominant values and developments in public organizations on the one hand and in society on the other. Active participation by citizens is seen as a key tool. (Askheim 2016:34)

In the following, I will reflect on the issue of "normative integration" evoked by Askheim (2016) and how municipal policy promotes a vision of how ideally speaking, disadvantaged individuals should normalise and reintegrate in society.

Normative integration revisited

I have already identified integrational efforts inherent to the recovery college along several lines, for instance, how the education frame places participants in a 'normalising' space from the perspective of the dominant majority: They are 'students' rather than 'service users' with mental health and/or substance dependence problems, something that may build down stigma and self-stigma, according to municipal representatives (and I may add here that this is a perspective that many service users also express, see chapters 5 and 6). Further on, the diversified classrooms and the peer teachers create a situation of 'merging of competencies' which may also bridge other discrepancies in terms of societal distance owing to factors such as cultural and social capital, and class in Bourdieu's (1977) outline. 'Learning from each

other' – including language and terminology - may imply an increase in cultural and social capital (especially for the disadvantaged who gain capital through competence-building), reduce stigma, create self-esteem and create understanding across societal divides – and hence, in the long run, facilitate that 'students' may partake with more ease in social life outside of the narrow circles of family and the health service contexts; e.g. in ordinary work places, classrooms and other organizational spaces.

I understand these aims as hoping that such measures will assist service users in becoming more self-reliant and less dependent on support from the municipal services for the future. This was also explicitly addressed in the presentation of the Nottingham model during a discussion in plenum, when the issue of 'graduation' from the college was presented: The students were encouraged to not take more than a year's study at the recovery college before *"graduating"* and moving on to *"other types of employment or study afterwards"*. In my observations, ideas concerning recovery seen as a process of 'normalising' and 'mainstreaming' – for instance, in terms of moving from a marginalised position as a service user towards becoming a 'regular' municipal citizen integrated in wider society (especially through the labour market or education sector) – were rarely challenged or questioned, at least explicitly, among participants in co-producing settings and in interviews taken. For instance, getting a regular job (and increasing one's economic capital) was generally recognised and admired as a recovery achievement across the mixed co-production settings of the recovery college (and across recovery research -see chapters 1 and 5), although in my experience not all those attending co-production settings felt this was the best option for them. The emphasis placed on 'normalcy' (cf. chapter seven) highlights that alienation from participation in 'ordinary' societal activities and contexts being "outside" – continues to be recognised as stigmatising, in a society that celebrates and finds comfort in a mainstreamed "sameness" and equality (Gullestad 2002): a normative integrational framework that may limit discussions regarding diversity and alternative recovery-oriented integrational aspects.

The issue of subcultures and integration

In the course of fieldwork, I experienced that the recovery college model was contrasted to other low threshold recovery-oriented services and was conceptualized as more radically oriented towards recovery in terms of reintegration in society. The municipality sees the recovery college as a new direction in the area of health care provisions and something of an antidote to the formation of insular subcultures around certain municipal low threshold services, in which a distance was maintained vis-à-vis 'majority society'. In the following,

excerpts from an interview with 'expert by education' W. offer insights into how the recovery college organisers' expectations for integrational achievements thereof, are contrasted to those of low-threshold activity centres:

> *Think if all the activity centres were good – okay, they have become good now. Before, it was more like – coffee and waffles. Now they have a lot of creative activities – writing courses, painting courses, some that go on walks together, physical activity, film nights, a lot of good things. But, at the same time, there is something that has been quite internal: they can find friends and activate themselves – they can also [continue to] live on the outside of the society. The recovery college – it has a completely different direction – towards integration in society again. Towards further education, towards work, towards the rest of society that makes a person a normal citizen of society. I think that is a recovery perspective that can make the recovery college much more powerful than an activity centre.* (Informant W., 'expert by education')

Here he argues that some of the shortcomings, more so in the past than now, with activity centres were that while they were overall well-meaning, they were too insular in nature and not as socially integrative as they could have been, a perspective also reflected in recent research on activity centres (Bachke et. al., 2017). These words were again strengthened by the sharp contrast draws between the two 'big ideas' of 'recovery colleges' versus 'activity centres' in a board meeting: When a user/caregiver representative asked for some clarification over the difference and what was new or innovative with the recovery college in relation to the activity centres, a board member ('expert by education') remarked that one of the longstanding problems with the activity centres, in the municipality's eyes, was their tendency to "*ghettoise*" and "*internalise*". The use of the 'ghetto' term also presents another issue when considering that activity centres were also discussed in the context of another meeting to be "*particularly open to individuals of non-ethnically Norwegian backgrounds and asylum seekers"* (J., 'expert by education'). Within that interpretative context, part of the issue with recovery centres, in some perspectives, may be that activity centres attract already marginalised groups, or groups that may been seen to be struggling to integrate to Norwegian society (Eriksen, 2013:5), and that these may further distance themselves from the goal of normative integration.

The worry is that the social circles formed around e.g. activity centres as homely places (talked about as cosy, friendly, safe havens, and so forth) may take on that of distinct subcultures that those who identify with them have no intentions to 'leave' for the sake of

integrating outside the centre. The recovery college in theory takes this issue and addresses it by setting sterner requirements for participation, the expectation of *"graduating"* and going on to other types of employment or study afterwards, potentially offering employment activities in the future for former students, and encouraging students to not take more than a year's study before 'graduating' as such (as in the Nottingham model) in order to combat this 'internal-orientiation.'

According to W., the formation of such subcultures is detrimental to successful recovery and integrational efforts by which former service users will take part in society on pair with 'ordinary' others, being more self-reliant and ultimately depending less on the services throughout their lives. There are also economic aspects involved in these lines of reasoning: Running the operations of a recovery college may be less expensive than running those of activity centres. Some activity centres have a mix of municipal and volunteer staffing, with paid municipal employees taking shifts, others are wholly user (and thereby unpaid volunteer) run, yet are municipally funded. Municipal and national governmental bodies worry about high expenditures in the health and social sector and the demise of the welfare state in our times, with a rapid increase in elderly in need of services, ever increasing social services costs, and where also influxes of migrants and refugees may pose challenges to the welfare state system (Justis- og beredskapsdepartementet 2017; Thorud, 2018).

The safe haven inside: a volunteer's perspective on the activity house

However, those whom I occasionally talked to who regularly use one or more activity centres as part of their recovery journey, talked rather highly of these meeting places and the activities offered. They talked about reduced loneliness and despair, somewhere to go to each day, and meaningful exploration of own resources alone and together with others, as central components in their recovery processes, as they themselves defined it. They argued overall that activity centres create options for a meaningful life – we may say in a 'co-production setting' with the peer support of others. A personal interview with 'expert by experience' R. shed more light on the seemingly controversial issue of activity centres, and their 'place' within the recovery landscape. She did not wish to be recorded, hence the following is based on notes taken. R. had been highly involved with activity centres in Bugard municipality over many years. She stated that one of the major positives and recovery-oriented aspects of the activity centre she was involved in, was that of providing "*a safe space*" that had primarily "*humans as a starting point – and [giving] food, love, something to do*." Rather than using the word "*users*", she pointed out that they focused on "*humans*" – "*humans that need a house, or a space, with a safe,*

homelike environment." She talked about the diversity of people, including ethnic diversity, and she emphasized the non-confrontational communication style promoted at activity centres: "*we (attendees and volunteers) don't talk about sex discrimination, religion, politics, we use common sense, common decency [in discussions] and attempt to avoid conflict*". When R. describe the environment within the activity centre she had been involved in for many years, she was at pains to point out how, in her words "*Those outside don't really understand the dynamics within it – what goes on here*" and paint the discrepancy between what outside institutions such as NAV and the municipality saw as problems needing to be fixed, and how those involved with the running of the centre and attending it/volunteering experienced it. She did gloss over the more serious concerns of some regular visitors at activity centres, saying that many "*struggle with their own everyday existence*" and there were many for whom activity centre attendance was a key part of "*not being sectioned – as they are afraid of.*"

From R.'s point of view, activity houses may represent spaces in which participants can expect to be taken at face value as humans regardless of their conditions, treated on equal terms regardless of former experiences and backgrounds, receive support if asking for it and also provide support to others, and where overall prejudices and conflicts she recognized as part of the dominant majority society, stay outdoors - in this sense, activity houses are oriented inwards rather than seeking to 'expand outward'. The centre in her view provides an egalitarian, human-focused environment that helps individuals with diverse backgrounds and mental health challenges to make empowered decisions to stay active, motivated by keeping well and being with others. The 'outer world' may be experienced by some as structured, competitive and demanding with regards to positions and expectations which may be difficult to master from a disadvantaged perspective, giving such 'homey' places a valuable role for those experiencing such disadvantage.

The container metaphor and normative integration

The issue of 'inside' and 'outside' orientations as evoked in R.'s reflections and in that of the municipal representative, points towards an overall 'container metaphor' (Lakoff & Johnson 1980) at work when issues concerning integration are implicitly addressed. From the municipal representative's viewpoint, the 'inside space' that everyone should try their best to be part of, is the mainstream majority society, as contrasted to the outlier "nodes" or "ghettoised margins," attendance to which may hamper "real integration." There is a sense here of unease with these ¨nodes' as existing 'within' but yet at the inside's outlier margins (services such as activity centres are clearly recognised as part of the fabric of municipal services, and as such, are part

of society's organizational spaces, nonetheless they are often discussed in terms of not fostering real integration as something outside of society). My interpretation is that there may be a sense of 'matter out of place' in this (Douglas 1966:33-36), from the perspective of the mainstream majority and normative integration perspective especially linked to participation in the labour market.

Can everyone integrate along normative recovery lines?

Slade et al. (2014) outline many potential misuses of or failures to implement recovery concepts in policy or within service provision, such as providers determining that certain patient groups are "too ill" to benefit; use of force (sectioning and forced treatment) justified through recovery application; and/or service cuts and closures after recovery orientation. They also point to the idea that "recovery is about making people independent and normal" and no longer in need of health services at all; and that individuals are only capable of "contributing to society" *after* recovery. For Slade, this expectation or implication is problematic, and represents a professional tendency to 'speak for' the service users. Davidson et al. (2005:486) suggest that "if we are to embrace an inclusive definition that implies all people can recover, it is possible that there will be increased social pressure on people that they must recover", and suggest that unrealistic expectations should not be imposed by treatment providers that may again reflect coercion. While much of the literature demonstrates positive results from adoption of recovery-oriented practices, it is not necessarily a 'one size fits all' approach: an Australian psychiatric study suggests that certain populations, such as elderly persons with mental illness, may struggle to adapt to the newer forms of recovery within healthcare (McKay, McDonald, Lie & McGowan, 2012).

Diversity in co-production revisited

In the following, I explore the 'culture issue' of the recovery college that was recognised by some of my informants – the tailoring of the program principally to ethnic Norwegians, although municipal policy documents reflect an overall desire to improve intercultural communication and integration within the municipality of Bugard: Official white papers from the Bugard municipality on diversity and inclusion promote the importance of integration for these groups in a variety of arenas, socially, culturally and with regards to education and employment, and states that health, standard of living, work, social inclusion and social participation are intrinsically connected and should be viewed together when creating policy for integration, particularly of especially vulnerable groups such as asylum seekers. It is further reflected on that ethnic minorities and vulnerable groups such as refugees and asylum seekers

have specific healthcare needs. The immigrant population overall in Bugard has increased steadily in recent years, with many residents with an immigrant background, many of these official refugees. Refugees are those who have been granted legal status as a permanent resident of their host country (Robjant, Hassan & Katona, 2009). Others still are in the process of seeking asylum but not yet granted refugee status, or otherwise displaced, with these three groups overall numbering in the millions worldwide (Robjant et al., 2009). Displaced persons globally have high rates of trauma-related health problems stemming from events prior to and during displacement and are more vulnerable to further mental health complications than other groups (Geronimus et. al., 2015). Increasingly restrictive immigration laws across Western countries, processes of detainment, risk of deportation and difficulties in obtaining legal right of stay have in themselves also been linked to stress and development of mental illness (Robjant et al., 2009; Eriksen, 2013). Given these considerations in municipal white papers, I was interested in how this translated into the recovery college setting.

Firstly, I will point out that despite the nature of this thesis as a study of intercultural communication and intercultural health, one of the main difficulties I had as researcher, was establishing to what degree cultural and ethnic diversity – as in not only Norwegian – perspectives and voices were considered in co-production of the Bugard recovery college. One of the limitations of this study is that there are few informants with ethnically diverse backgrounds. This is due to the recovery college project being developed by entirely ethnic Norwegians, in Norwegian. Although the participants interacted to some degree with other recovery colleges, for example at the competency-building course delivered by representatives from Nottingham, England; and some travelled to Denmark for research and development purposes during the course of the development period (not part of my data collection), for the most part this organisational setting operated within local and linguistic confines. In the following I explore considerations regarding ethnic and linguist diversity during the co-production of the college itself, the courses and in recruiting students and teachers, this given the ethnically diverse composition of the municipality's population that the recovery college is to serve.

Engaging with the issue of diversifying

The right mix of competencies was a central issue discussed when creating application forms and when recruiting students to the first college courses. Both 'experts by experience' and 'experts by education' recognised that the recovery college would have to consider diversity in a more fine-masked sense when selecting students to the courses, and that the overall frames

of ‘expert by experience’ and ‘expert by education’ maybe would not suffice to guarantee *“the right mix”* in order to facilitate the *“magic”* explored in chapter five. The excerpts from a dialogue during a meeting exemplify this:

> *Do we have the necessary diversity? In the fields of mental health and substance use, we also think about diversity – both genders, preferably both in 40-50 age group, but also younger, different personalities, diverse competencies. Someone with their own experience, others with other skills. There is no one profession or job role that is the perfect one; it is actually the diversity that is the strength.”* (Informant L., ‘expert by education’)

In the above excerpt there are several examples of what informant L. argues is positive diversity, diversity which creates *“strength”* – diversity with regards to having different ages, genders, *“personalities”* and competencies in one working environment. When listening to discussions regarding ‘this mix,’ I rarely came across the issue of including ethnic, linguist, or cultural diversity. In order to flesh out the intercultural aspects of the recovery college and find all the information I could about potentially opening for students of culturally and ethnically diverse backgrounds, I discussed these matters with several informants, as I will outline in the following.

The issue of ethnic, linguist, and cultural diversity

For the most part, those involved in the recovery college project were open to the idea of engaging with cultural and ethnic diversity, both in co-production settings and in the context of potential students. During a co-production meeting, ‘expert by experience’ Q. said that she “*saw no reason*” to not find a way to address this. Another time, informant S. stressed that ensuring access for an increasingly ethnically diverse patient population should become a key area of focus for the recovery college board for the future:

> *“I was, at the least, very concerned with it while we were travelling. I see that I am a bit embarrassed now… because we haven’t been more concerned with it underway. But – the next meeting, I’m definitely going to take it up. Because it is important, definitely important.”* (Informant S., ‘expert by experience’)

Informant L. responded slightly differently to similar questions, answering saying:

We haven't exactly thought much about it in the planning of the school, that I will just have to admit. When we were in Nottingham, there were indeed many that were not ethnically English, people that you could notice. I think today, in relation to residential services and other services, there are a good deal many users who are not ethnically Norwegian." (Informant O., 'expert by education')

When I raised the issue of this aspect of diversity and mixed competencies, there seemed to be an overall agreed that eventually the recovery college would have to deal with the issue of ethnic diversity, also recognising that non-ethnically Norwegians and refugees easily could miss out on important recovery-focus services and were hard to capture before conditions had worsened. In an interview, S. ('expert by education') expressed it in this way:

I think we likely have to discuss it on many different levels. Here some of the bureaucratic things which I am not that thrilled about. We're going to have many different opinions about it. There's going to be probably those who are a bit like… 'Yes, you came to Norway with another language, so you're going to go to school, and learn, so that you can speak… The idea is that you will understand. But, reality isn't like that. There are those than come in who are not in any condition to learn, have maybe experienced war and trauma, and maybe they aren't in the right place to sit at a school desk, have those types of lectures, but can still have some use of a six-week course with us. We have to – for god's sake! – try to catch some of those individuals, and try. I think, overall, it will be exciting. Maybe we can have volunteers who know the language, that can be translators. How about that?" (Informant S., 'expert by experience')

S.'s emphatic reflections as above are a reminder that for many individuals immigrating to Norway, learning the language is not as simply as attending the (for some) mandatory introductory program (cf. Eriksen, 2013), or some night classes, for example, and that the reality of lived experience as a refugee of war, for example, presents its own unique challenges along with those of adjusting to and integrating into a new society and culture. However, although S. clearly sees this as a challenge – he paused several times while considering the challenges present in the question – he goes on to emphatically and decidedly state that, *"for God's sake!"*, it should be a priority of the college to reach out to these individuals *because* of their experience and difficulties, rather than avoid them because of the logistical or bureaucratic challenges involved in creating accessible content. Interestingly, S.'s comment about "*the bureaucratic things I am not thrilled about*" may offer a contextualising argument for some of

the frustrations he expresses: he feels to some degree held back by the amount of change the recovery college can affect, due to bureaucratic concerns, for example that of sufficient *"time to do"* as touched upon in chapter six.

The issue of the 'guest role'

In the next excerpt, informant L. hints at the possibility of bureaucratic concerns holding back intercultural possibilities for the recovery college, contending that it was difficult to address many different concerns simultaneously:

> *"[in the services already] there are a lot of users who are not ethnically Norwegian. Also in the activity centres, I meet often four or five each time I visit one that are from other parts of the world. [However], it is dependent on a certain language capability… I don't see the possibility of having a recovery college with a translator. But when someone has the sufficient language skills to participate I think we must indeed try to perhaps invite someone for co-production or have teachers of another background at the school. I think that will be a stage two. It is difficult to make everything happen at once."* (Informant L., 'expert by education')

Informant L does not rule out the possibility of an interculturally diverse recovery college – suggesting that a "stage two" for the recovery college could be having someone of "another background" as teachers or "*inviting someone for co-production*". L's statement concerning "*inviting someone for co-production*" caught my interest: it suggests perhaps that this person of *"another background"* will be brought in from 'outside', invited in, rather than being perhaps a permanent recovery college organiser. This excerpt may reveal a dynamic presupposed whereby one group – those who already have the decision-making power within the recovery college have the power to decide on what terms and for what purposes someone of a non-Norwegian background will be 'invited' into the co-production environment (stage two, we are told). This implies that the 'inner' field of co-production or teaching is not quite ready for the invitation to or introduction of intercultural perspectives, and the involvement of the non-Norwegian perspective in this hypothetical sense must then wait to be invited. The act of invitation, however, while informant L. phrases it in a positive way – carries unseen expectations for the individual on the receiving end, as well.

One theoretical interpretation could be Goffman's concept of a "supportive interchange", which creates access to new situations through the rituals of introduction

(Goffman, 1971:78-79). The greetings, social rituals and contact implied in these settings (co-production, the teaching environment, et cetera) create a "temporary period of increased access", where two individuals who may only have greeted each other in passing previously, before, will now greet each other in a setting which can "mark a transition to a condition of increased access" (Goffman, 1971:77-79). Gaining that access in this situation may be positive for a time; however, this condition remains in a temporary state. In the hypothetical situation I am attempting to sketch out, part of the issue with this state is that one party is in it permanently, and another more temporary, and the working relationship continuing may well be contingent on the *temporary* visitor's behaviour. Gullestad's metaphor of the "home" and "guests" with regards to immigrants integrating into Norwegian society is relevant here:

> The home as a metaphor establishes sharp boundaries between the nation (the home) and the outside world (the foreign guests). The very categories 'host society' and 'guests' thus construct a hierarchical relationship with the 'immigrant' at the receiving end (Gullestad 2002:55).

The Norwegian individual inviting the non-Norwegian individual into the 'home' of the co-production or learning environment in doing so additionally creates a 'guest' role for that individual. In general, guests are expected to be polite, to not make demands, to not overly change the landscape of the other's "home" environment, as it is not their own. In this type of workplace dynamic we see elements of Goffman's "informal social control" as applied to work situations, what happens if the individual steps outside of the invisible, yet present framework implied in the power dynamic – if they go too far beyond their 'field', and "violate the informal rules for the management of personal place?" (Goffman, 1971:360).

The issue of fear of racism

In an interview with informant S., he reacted surprised but grateful to receive my question regarding inclusion and ethnic and cultural diversity, commenting that he thinks it was good that I asked and mentioning as well that he in fact asked a similar question while on a study visit to Nottingham Recovery College, with regards to service users with diverse ethnic and language backgrounds. He went on to tell me that the representatives from Nottingham had replied with that they had translators, mainly of a voluntary nature, a type of *"study buddy"* in Nottingham's words, that participated in courses along with the other students, and ensured that those with a foreign background could participate fully. He reflected on Nottingham's response, as well as the reactions of the Norwegian group while discussing this on their study trip:

I was the only one who asked over in Nottingham – how is it with users with different backgrounds, with different languages, et cetera. And they replied that they had translators, and volunteers as well, that took part in courses to ensure that people with a foreign language – no, a different ethnic upbringing, a different language and so on, could participate. They are open to that, they had a question in the survey for taking a course that asked you if you had a different religion, where you live, what is your ethnic background… That can give, actually, when we *read it, I see it's possible at someone will react to that. They find it slightly racist – why do I have to answer that? I think that's going to be a challenge."* (Informant S., 'expert by experience')

S. brought up the issue of how attempts at 'catering' to cultural, ethnic and linguistic diversities, through asking for the provision of information such as ethnic background, preferred language and so forth from students, as in his description of Nottingham's process, can risk causing harm for some individuals, despite being designed with positive intentions for assisting students from diverse cultural backgrounds. It is interesting to consider the different reactions that might arise from designing forms, for example, in such a way as to catch information. A general application form designed with only Norwegians in mind, would likely ask about *bosted* (place of residence), *fødselsnummer* (individual identification/social security number), among other things, and would assume that the individual answering has a Norwegian identification number and a permanent residence without necessarily needing to verify citizenship, or language capability. A form designed with other nationalities in mind might also be made available in English, ask about what languages someone speaks other than Norwegian, or ask about place of birth as well as place of residence.

S. is concerned that potential students will find a form that asks for this information to be slightly racist and feel defensive about why they should need to provide that information in the first place. The implication here is that asking questions about difference points out, makes clear that that difference is there, that it is worthy of notice and therefore outside of the norm. As in Gullestad (2002), focusing on an individual's place of birth and status as *innvandrer* can be frustrating and disturbing for those who 'feel' themselves to be native, speak Norwegian, but are still categorised in the eyes of Norwegians as immigrants, not quite outsiders, but not quite insiders either, and suggests that identity and culture are stagnant, dependent only on one's native culture, leaving one always an *innvandrer* when they step into the borders of another's native culture, or in Gullestad's words, "not one who has entered, but is always

entering" (Gullestad, 2002:51-52). The negative reaction informant S. is unsure about in attempting to *create* diversity, *embrace* difference in the recovery college is a result of this problem: by aiming for 'diversity', one also risks highlighting difference, the 'us' and 'them', the 'inside' and 'outside', and creating a framework where identity is decided on for certain people, by others on the 'inside'. As Gullestad argues:

> Such unacknowledged frames of interpretation operate, so to speak, behind people's backs. Even when the intention is equality and dialogue, the interpretative frames may still contribute to anger and distance. Such frames are not accidental ornaments, but intrinsic parts of any argumentation. Talking about the relationship between 'immigrants' and 'Norwegians' means that a specific frame of interpretation is applied, constructing a difference, which then has to be bridged (Gullestad, 2002:51).

Will immigrant applicants 'fit'? The question of recruitment

At the time of writing, all Bugard recovery college courses, course information, and application processes were in Norwegian, so this in itself implies that one would need to have a fair comprehension of the Norwegian language just to apply as a student. The online application form does ask about background of a different nature, by requiring students to answer the question "On the basis of which role are you applying?" Three options are given: "Service user" "Caregiver" or "Staff". One could argue that, given the college's focus on the removal of role dependency in successful co-production (the 'magic' element in co-production), it is interesting that this option is required in order to apply. On the other hand, this can potentially be a useful method for ensuring that competencies are evenly balanced in classroom settings. Students will also undergo personal interview (although even the name of this particular tool was contentious – at board meetings, it often became a short discussion over whether it was an *interview* or a *conversation*)[20] in order to determine whether they were was a good 'match' for the course they had applied for, and vice versa.

Considering this and taking into account L.'s worry about 'racism' in the last excerpt presented, I see also a potential downside to informant L.'s caution about asking for certain characteristics – a method such as this might well be designed for the purposes of *increasing* the diversity of the student pool, but could also easily be used for the opposite purpose, depending on who has the authority to decide what the student pool should look like and what a good 'match' for the course means. For instance, applicants who were rejected on the basis of not being a good 'match' for the course or not being 'far enough' in their recovery journey

might assume that they had been rejected for a course place due to nationality, for example. Individuals who feel otherwise ‘integrated’ as well, and see themselves as Norwegians, perhaps, although not having been born in Norway, might also be bothered by the focus on nationality, native language, and so forth.

Differences between the Nottingham model and Bugard’s model-in-development

The Nottingham recovery college has information such as prospectuses available in a variety of languages, although all its courses are taught in English, which again implies an expectation present in that those who will attend will have mastered English to a certain degree. Research has shown that significant numbers of the migrant population in England still struggle with gaining English proficiency and a costly and restricted language learning system, making integration into work and social life more difficult (Gimson et al., 2012). The Norwegian language and difficulty attaining fluency as an immigrant has also been established as a barrier to social integration and eventually gaining citizenship in recent official policy (Justis- og beredskapsdepartementet, 2017).

Many Norwegian universities and schools offer courses in English, so perhaps it is not unreasonable to think that Norwegian recovery colleges might also consider doing so in the future. Overall, it would appear that Norwegian society increasingly is becoming more diverse, prompting a change in how Norwegian cultural identity will come to be defined in the future (Eriksen, 2013). Reflecting back to England, research suggests that around only 10% of the English population (a significant decrease) still believe that ethnicity with regards to skin colour and background is an important factor in “English” identity, with other factors such as “contributing to English society” seen as more crucial factors for ‘allowing’ individuals with diverse ethnic backgrounds to identify as culturally “English” (Alexander, 2019). This suggests that assimilation is not, or at least to a lesser degree, the goal of integrative measures to establish “English” culture – rather than “to make alike” and make the same as in Døving (2009:9), the diversity and contributions of diverse groups to the overall society make up a picture of English culture via “integration” as in Døving (2009:9-12): essentially efforts to reduce discrimination and inequality while maintaining and accepting multicultural diversity. Norway, on the other hand, is generally depicted as ethnically more homogeneous whereby other cultural groups tend to be forgotten in official policy:

> Norway is an assimilationist, rather than a pluralistic country.. This may be because of cultural traditions in Norway, which up to recently used to be a culturally homogenous country, but also because of the rather small size of the immigrant groups, and their up till now small cultural impact on the Norwegian community. In Norway there is a strong pressure on immigrants to adopt Norwegian language and Norwegian customs, in spite of the public policy being "integration" rather than "assimilation". Even if the immigrants may keep important elements of their own culture if they are not in open conflict with the Norwegian culture, they are expected to adjust rather quickly to the Norwegian society. Over time this may have a positive effect on the mental health, but in the short run it is likely to create stress and mental health problems (Dalgaard et. al, 2007:9; translation mine).

Norwegian municipalities and the Norwegian state's official policies do take on multifaceted approaches to integration via work opportunities, language learning and increasing awareness around discrimination and diversity (Justis- og beredskapsdepartementet 2017:2, Thorud, 2018). In Eriksen's (2013:5) words: "The thrust of Norwegian policies toward immigrants has trended in the direction of equality, sometimes understood in terms of assimilation." Anthropological scholarship has sought for some time to analyse the relationship between equality and 'belonging' in Norwegian society and sameness, the apparent preference for similarity within the egalitarian structure of Scandinavian social values (Bruun et al., 2011). Bruun et al. (2011:2) argue that hierarchy and equality via similarity or "sameness" (Gullestad, 1992:174 in Bruun et al., 2011:1) have a complex relationship whereby people's shared values, concerns and attitudes about social life form and maintain the overall social hierarchy – for example appreciation and value of social forms such as *hygge* (cosiness) and *fællesskab* (community) in Danish society, which are also reflected in Norwegian society as the importance of *kos* and *felleskap*. Shared knowledge of, appreciation of and reflection on these traditions and forms for social existence are relevant to being included or excluded and introduce hierarchies within social life (Bruun et al, 2011:2). Many authors such as Døving (2009) and Gullestad (2011) have discussed how the underlying focus on sameness as an integral part of equality in Norwegian culture make it difficult for those deemed to be not the same to integrate and belong within the majority Norwegian society, regardless of how Norwegian they 'feel'. Writing in the media around Norwegian identity and sameness and the barriers and invisible hierarchies created by the need for sameness also abounds, such as in Skartveit (2015) and Åmås (2016). Åmås (2016) described the "Norwegian package solution"

whereby all aspects of a person's identity, behaviour and value system must be alike and ascribe to the majority norms, leaving little to no room for multiple or conflicting aspects of identity, and are often inextricably tied to place of birth and ethnicity – where one is "actually from" versus where one "feels" that they are from.

In contrast, a multiculturalist society has additionally self-awareness and politics that "…looks after its diversity" (Døving, 2009:7). United Kingdom has long been established as a multicultural society, which is not to say that it functions perfectly as such but rather that for a much greater period of time than most Norwegian urban and rural places, it has been culturally and ethnically diverse. This would suggest that with effective measures in place to integrate individuals into English society via language, work and through more interculturally diverse services for vulnerable groups, many individuals who might have in previous years struggled to integrate and remained 'outside' mainstream English society would have a reasonable chance of feeling integrated and being accepted as integrated, with a more broad definition of "culturally English" allowing for acceptance or celebration of ethnic and linguistic diversity within these boundaries rather than the suppression of it. This suggests that assimilation is not, or at least to a lesser degree, the goal of integrative measures to establish "English" culture – rather than "to make alike" and make the same as in Døving (2009:9), the diversity and contributions of diverse groups to the overall society make up a picture of English culture via "integration" as in Døving (2009:9-12): essentially efforts to reduce discrimination and inequality while maintaining and accepting multicultural diversity. Ensuring diversity for the purposes of co-production in both the boardroom and the classroom, as we have seen, was a key concern for the recovery college.

Summing up this chapter

This chapter has dealt with issues related to normative integration and how this translates into the recovery college relative to other services such as activity houses. Gullestad (2002) describes the Norwegian tendency towards the desire to categorise, as part of an "imagined sameness" between those who are Norwegian, making clear the "invisible fences" between those who are living in Norway, but "not quite Norwegian" in these types of social interactions (Gullestad, 2002:47). This reflects the underlying and often unspoken concept that there is an 'in-group' that is made up of those who confirm to mainstream standards of societal, social and cultural norms; having a job, gaining an education, having a social network, being law-abiding, and so forth. In Bourdieu's framework (2013 [1977], 2017, 2006), it is the economically and

socially privileged and powerful who sets the ideal trends and represent the ‘in-group’, they dictate the high standards of taste, comportment and lifestyle, and so forth.

Society’s many layers of complex social, political, economic and cultural norms and rules for comportment are often revealed by those who supposedly fall “outside” or do not conform to these, much more clearly than expressions of everyday conformity. This tension is directly related to marginalisation and stigma, as stigma overall is a social framework used to categorise those individuals, behaviours or traits which are considered deviant, unacceptable and those which are not. The interaction in co-production settings between individuals who identify themselves as belonging to the dominant majority versus those who have been (or are) associating themselves with marginalised subcultures is examined in this chapter, whether within the ritualised, organisational field of the co-production meeting with its uniform white coffee cups on a long conference table, the expansive networking conference where service users give lengthy descriptions of potential course ideas while professionals sit with notebooks in hand, or outside bureaucratic buildings in the designated smoking area between discussions on the nature of clinical versus personal recovery. In the context of the recovery college, the dynamism of culture, stigma, competence and societal expectations become relevant for many issues, for example the issue of distinct subcultures and identities to which persons with substance dependence issues and psychological problems may have belonged to or variably identify with, which recovering may require distancing from as a result of stigma amongst other factors (Pinxten & Lievens, 2014; cf. Landheim et al., 2016:47-49 and 61-62). For others, the process of recovering may be about “reclaiming” stigmatised phenomena related to their experiences (Slade, 2013:31-31; Fernandez et al., 2014) and integrating into everyday life with their “new identities” in terms of belonging to a – for them – positive and recovery-rewarding subculture such as those formed around activity centres, rather than seeking to downplay their experiences.

Conclusion

In this study, I have explored the phenomenon of co-production through the multifaceted settings of the Bugard recovery college project and at the crossroads between agency and structure. The impact of otherwise recognised asymmetries, positionings and authority structures as they relate to forms of competencies and capital, do have an impact on the co-production space, despite it being initially defined as democratic and devoid of asymmetries, with co-production as the equalising tool. While the innovative and radical nature of co-production and equalisation of diverse competencies has been for the most part experienced as positive by both those involved in project development and the students in the pilot, wider cultural discourses that have a rich context outside of the co-production space have been seen to play out within this environment, impacting measurably the experience of co-production for various parties and the types of 'products' or content co-produced along the way – these have been demonstrated through the development process of the "turning point" and "experience presentation" methods, among others. I have explored different interpretations of, and experiences with co-production, and the larger issues they evoke and reflect, whether in conversations and interviews, in the course of social interaction in co-production settings, or in terms of official statements and municipal policy.

Firstly, I will say something about co-production within the recovery college itself and how co-production seems to have been experienced by the parties involved. I would argue that I have evidenced co-production occurring at various stages via analysing different examples of co-produced content and the contexts in which they were created. Shared competence-building via co-production was generally expressed as most valuable when experienced not as a one-way street but a dynamic and equal interplay, where everyone should offer what they can, and crucially, feel that their contribution is valued. Each course can reasonably be said to have been co-produced, and the college groups were very dependent on course feedback from the first run of students. All courses from the pilot run had mostly good testimonials from the students, with self-reported increases in competence, increased social connection, positive feelings about one's self and one's future goals, and desire for longer and more involved courses. The main caveat seems to have been indeed that in some cases, more practical-based learning was desired, with some courses experienced as unnecessarily theoretical. Sometimes, those with education-based competence were experienced by others within co-production settings to be very focused on theory, content and appearance of courses, whereas those with experience-based competence felt that the end result, conceptualised in the overall experience and

outcomes of students, was the best indicator of whether the college was successful in its aim. It was also expressed that the 'magic' of co-production also is related to its unpredictability and difficulty to measure – all individuals are different, and the real recovery work of co-production in the classroom should come "from each other", not from a lecture or homework task.Certain methods and models retrieved from previously established colleges may have impacted what types of content were implemented in the final three courses. It will be of great interest to see how feedback from the pilot run is utilised to adapt the future college, and how the college itself grows as a result of co-production, both in the boardroom and the classroom.

Secondly, I have explored some paradoxical dimensions involved in the creation of an egalitarian space within the frame of an otherwise hierarchical municipal structure, with co-production as an equalising tool. Here I have attempted to find out how co-production has been experienced at various times and in different settings by participants who are differently positioned with regards to their competencies, perspectives on recovery, roles within the overall health and social welfare systems and roles specifically within the recovery college project. Much of this thesis has actually been devoted to questioning how and whether asymmetrical relationships and competencies otherwise recognised, may translate into the recovery college settings - and in themselves potentially changed in various ways by the discourses engaged in the co-production settings themselves. For instance, the determinedness of co-production facilitators in having a democratic 'balance' of voices in the co-production setting may have contributed to some participants feeling 'defined' or very aware of their role at times, despite the intention being for all roles to dissipate. Those with diverse competencies could often relate to being asked specifically for one type of competence over another, and expressing that they were feeling like they were occasionally "*between chairs*". 'Moving between' knowledge forms or roles was not always experienced as *"magic"* or easy. Even when individuals themselves are positive to recovery orientation, diverse voices and the democracy of co-production settings, structures of hierarchy and delineation of power throughout the health and other systems can be seen to be 'speaking through' dynamics and conflicts between differently positioned actors inside the co-production space and outside of it. Protected titles, licences and certain competencies were in some cases seen as a hindrance to recovery-focused working, as well as legal frameworks related to risk and mental health. Although challenging, it may perhaps be easier for 'experts by education' to shed role in co-production settings, perhaps due to a feeling of established comfort or privilege attained through their roles outside of the co-production settings themselves. After all, they are in many

ways still afforded agency, power and social capital as these translate partly into the recovery college settings. It may be easier to set aside a role which they know they can comfortably retain when desirable. 'Experts by experience' may have in some co-production settings a harder time setting aside their role due to concerns about the realities of the co-production space, and how perceptions of their role may be impacted by participating within that space, for example due to prior experiences of stigma, and potentially owing to concerns regarding how they are being perceived by 'experts by education.' We saw that 'experts by experience' led many discussions in co-production settings and produced methods and content for 'teaching recovery', but cautioned that in some cases the 'education' voice may need to be held in slightly lower regard in order to maintain balance, and pay respect to the newer voices in the co-production space that have traditionally had less of an autonomous 'voice'. Hence, the 'microcosm' of co-production and those within its confines must be aware of wider societal discourses around the themes and ideas said to be being co-produced. It is also evident that 'experts by education' must exercise caution in certain regards, for instance legal ramifications, and as such experience restrictions to 'letting their role go,' while 'experts by experience' may in this respect be freer. Although in some scenarios for example experience consultants and other 'experts by experience' are arguably better placed and 'freer' to bring about change due to not necessarily being restricted by licences, legal reservations and protected titles, and the discourse around risk in mental health, this 'freedom' may also make clear the continued asymmetry between positions of competence by experience and positions of competence by education.

Thirdly, I identified that the interactions between parties engaged in co-production processes reflect larger discourses around recovery, social integration, stigma and discrimination, and culture. Throughout this study I have explored various structures and dynamics which appear to influence participants' experiences of co-production and broader themes of the recovery context within intercultural health. Without necessarily intending to, those in the privileged position of making certain decisions about project development, from course content to logistical concerns such as when meetings would occur, tended to schedule and structure the development of the project to suit their own, already quite full work schedules and other demands on their time. Those in certain positions within the systemic hierarchy of the municipality were required to utilise the capital inherent in their position in order to solicit funding, justify to politicians the importance of the recovery college and argue for the use of municipal time. However, this may have had the unintended consequence that those technically

lower in the hierarchy who were invited to or desired to become involved had less agency over their schedule and the time they devoted to the college project, as well as confusion over how time should be managed within contracts, schedules and other work commitments. To their credit, the municipality has considered time used and resources required of those involved and has designed measures for combating these problems in future.

How have prior experiences within the health services and in the wider context of society influenced the ways in which 'experts by experience' and 'experts by education' have engaged one another in co-production settings? For instance, it has been important to explore how prior stigma processes may translate into co-production and perspectives around experience-based competence. Strength in combatting stigmatising attitudes was to be found in community and in shared experiences, whether in educational programs such as the MB-program or in co-production settings. On some occasions well-intended comments and interactions could result in disagreements, potentially due to prior experiences with stigma and discrimination – from either 'experts by experience' or 'experts by education'. Different parties involved in co-production often displayed differing ideas on what aspects of recovery philosophies should be prioritised, keeping in mind that these choices may have a real-life impact on eventual students' perspectives. Differing perspectives on how the college should situate itself within the interdisciplinary territory between 'education' and 'health' also came to the fore, with wider discourses of stigma around mental health and particularly the specialist health services and concerns about being overly associated with aspects of these services that were viewed by some as negative, and additionally the framework of the law and risk coming into play, meant the college made great efforts to establish its position firmly in the 'education' field. This is one factor that has shown the recovery college to be particularly special and necessary for the municipal services. Co-production and the way it was introduced and experienced within the context of the recovery college, and how do the participants envision the project and its role within the structures that exist today, and especially with respect to promoting recovery?

What is the relationship between the recovery philosophies promoted by the different parties involved in co-production - and the issue of normative integration in overall society? Norwegians in particular may tend to conceptualise equality in "sameness" and the integration into accepted and valued positions in society. Normalisation in social integration via recovery was also seen as a key goal for the recovery college. Many with backgrounds of service user

experience were adamant that the goal should be treat everyone ‘normally’, arguing for the importance of stigma reduction and not desiring any kind of ‘special treatment’, whether in the workplace or for the eventual students of the college. In the debate over how recovery colleges should ‘face outwards’ as opposed to other local measures, as well as discussions around how the college should position itself in the context of already existing structures and promoting recovery, discussions around the ‘individualised’ aspects of gaining recovery capital, ‘healing oneself’ and ‘feeling better in oneself’ were pitched. Others felt strongly that too much ‘individualised’ focus on learning principles for living better were not as radically recovery-oriented as the college’s potential for ‘recovery in practice’, which could incorporate various outdoor, social or creative possibilities.

With reference to the potential for ‘co-producing’ ethnic and cultural integration for newcomers to Norway: expansion to multicultural or multilingual courses or options for the college was treated cautiously by some, particularly those with education-based competence, who foresaw logistical and planning difficulties as well as in some cases expressing that certain requirements for language should be present for potential students. There may be an inherent reluctance to ‘over-adapt’ away from the Norwegian linguistic and cultural setup of the college, perhaps related to the structural relationship between social hierarchy and individual values, concerns and appreciation for cultural norms. This may mean potential disagreements over ‘how integrated’ future students should be before applying – and what measures of integration will be used? I have found that in the light of the increasingly culturally and ethnically diverse context of Bugard municipality, there is a need for considering how the college can facilitate the inclusion of immigrants, so that the college can be placed to assist and address also their concerns. Although highly dependent on issues such as time pressures and financial access, it has become apparent, I believe, that the project has principally been tailored to suit ethnic Norwegians. Diversity in competencies and experiences was expressed as a major positive of co-production, however diversity with regards to culture and ethnicity was overall lacking in these scenarios. Processes of inclusion and exclusion of other stigmatised or ‘outlier’ groups were also reflected in subtler ways. Most participants saw the inclusion of diverse cultural perspectives and the ability to potentially expand language-wise as a logical and necessary next step and something the college must find resources for and ways of working to accommodate in its future. All in all, co-production evolves at the crossroads between agency and structure and becomes a lens through which the themes of integration, stigma processes, cultural diversity, equality and hierarchy are explored.

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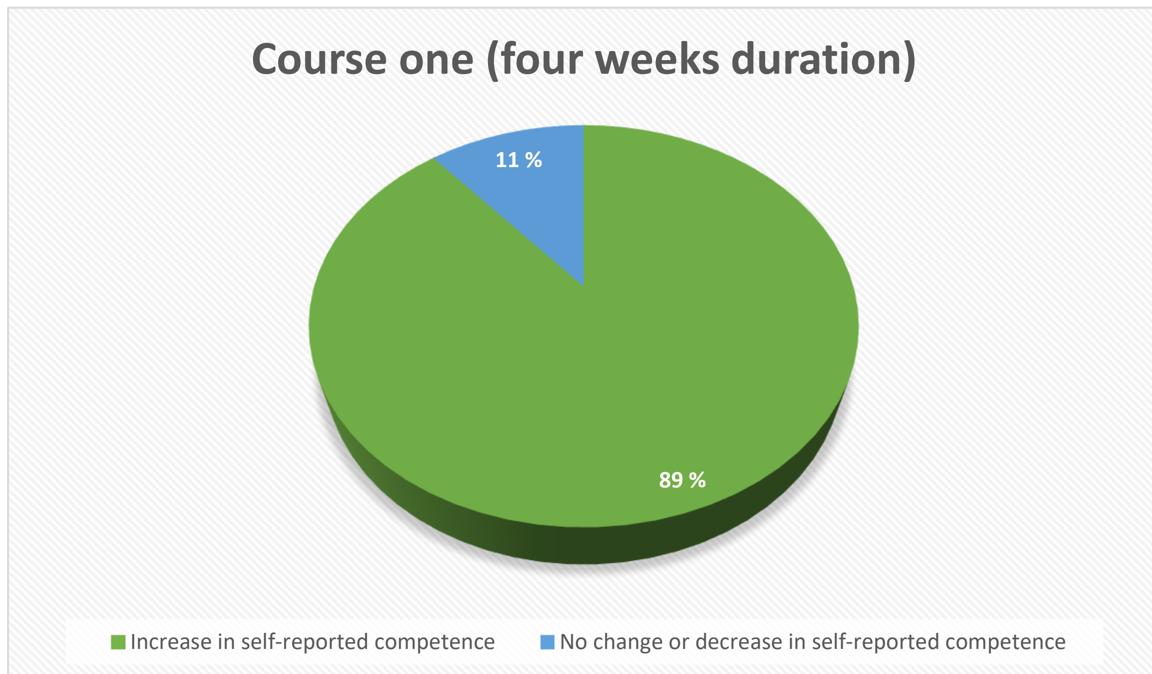
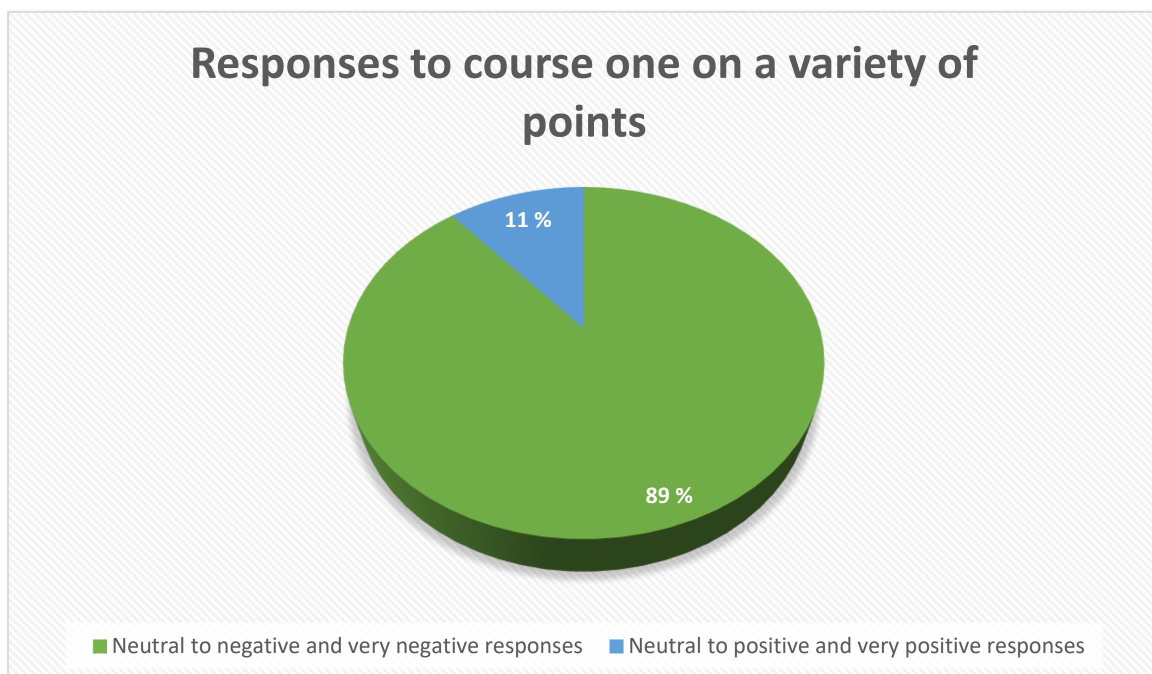
Appendix 1

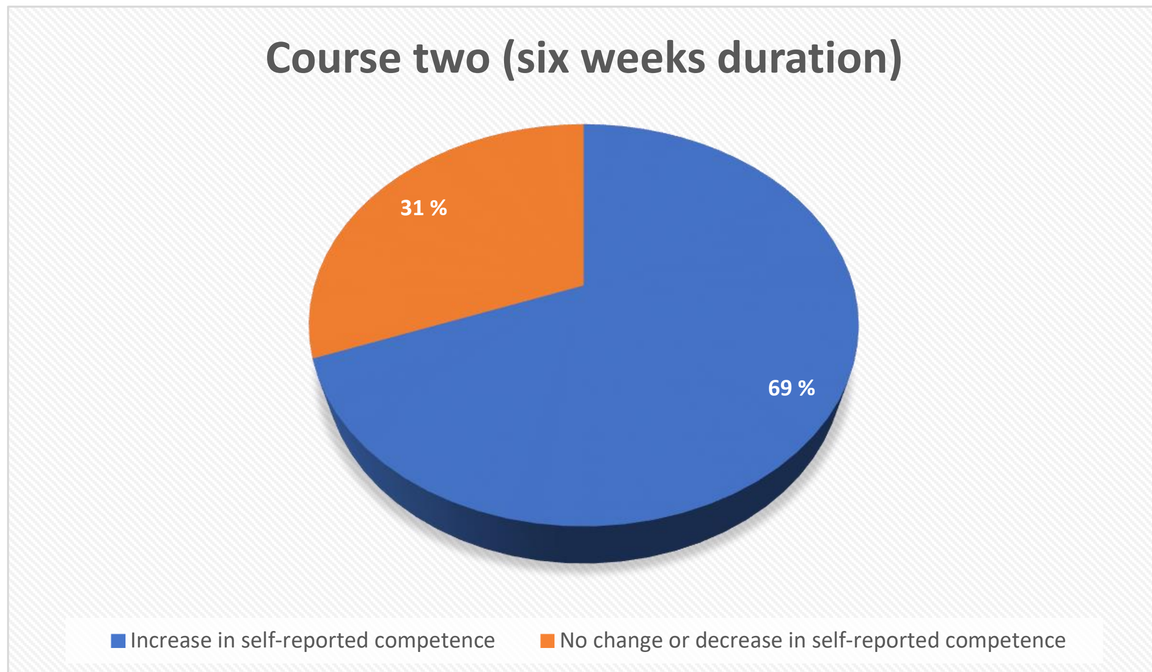
Analysis from student feedback of the pilot semester of the Bugard recovery college.

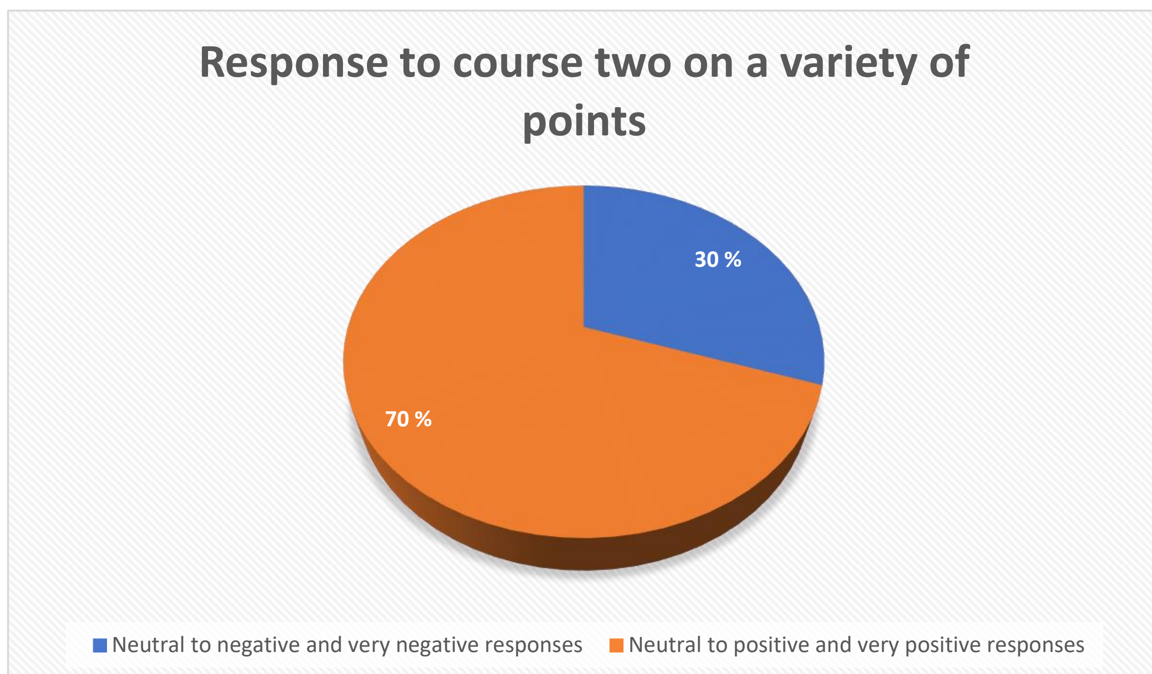




Other comments:

Most respondents reported desire for a longer course time and more practical mindfulness activities. Co-produced content received generally positive responses.

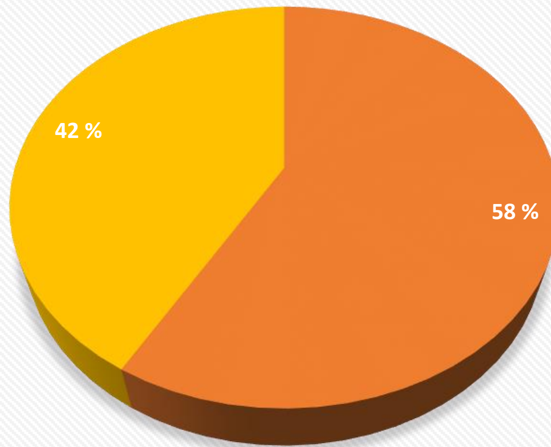




Other comments:

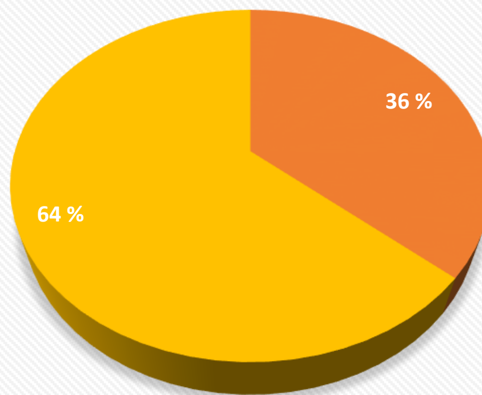
Less than half felt the course to be too short. Specific comments stated they would prefer more focus on body positivity and more practical based learning, such as use of school kitchen or group training at training centre with less theoretical lectures. Certain co-produced methods received general praise.

Course three (two weeks duration)



Increase in self-reported competence   No change or decrease in self-reported competence

Responses to course three on a variety of points



Neutral to negative and very negative responses   Neutral to positive and very positive responses

Other comments: Several respondents reported the course to be too short. Overall, coproduced content and modules received a positive response.

Appendix 2*

Marit Brendbekken
Postboks 74 Sandviken
5812

Vår dato: 18.07.2018 Vår ref: 61060 / 3 / EPA Deres dato:
Deres ref:

Vurdering fra NSD Personvernombudet for forskning § 31

Personvernombudet for forskning viser til meldeskjema mottatt 08.06.2018 for prosjektet:

61060	*Vi lærer Recovery - Et studium av satsing på Recoveryskolen 2018.*
Behandlingsansvarlig	*NLA Høgskolen AS, ved institusjonens øverste leder*
Daglig ansvarlig	*Marit Brendbekken*
Student	*Rose Elizabeth Boyle*

Vurdering

Etter gjennomgang av opplysningene i meldeskjemaet og øvrig dokumentasjon finner vi at prosjektet er meldepliktig og at personopplysningene som blir samlet inn i dette prosjektet er regulert av personopplysningsloven § 31. På den neste siden er vår vurdering av prosjektopplegget slik det er meldt til oss. Du kan nå gå i gang med å behandle personopplysninger.

Vilkår for vår anbefaling

Vår anbefaling forutsetter at du gjennomfører prosjektet i tråd med:

•opplysningene gitt i meldeskjemaet og øvrig dokumentasjon

•vår prosjektvurdering, se side 2

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.

•eventuell korrespondanse med oss

Vi forutsetter at du ikke innhenter sensitive personopplysninger.

Meld fra hvis du gjør vesentlige endringer i prosjektet

Dersom prosjektet endrer seg, kan det være nødvendig å sende inn endringsmelding. På våre nettsider finner du svar på hvilke endringer du må melde, samt endringsskjema.

Opplysninger om prosjektet blir lagt ut på våre nettsider og i Meldingsarkivet

Vi har lagt ut opplysninger om prosjektet på nettsidene våre. Alle våre institusjoner har også tilgang til egne prosjekter i Meldingsarkivet.

Vi tar kontakt om status for behandling av personopplysninger ved prosjektslutt

Ved prosjektslutt 23.12.2018 vil vi ta kontakt for å avklare status for behandlingen av personopplysninger.

Se våre nettsider eller ta kontakt dersom du har spørsmål. Vi ønsker lykke til med prosjektet!

Katrine Utaaker Segadal

Eva J. B. Payne

Kontaktperson: Eva J. B. Payne tlf: 55 58 27 97 / eva.payne@nsd.no

Vedlegg: Prosjektvurdering

Kopi: Rose Elizabeth Boyle, rose.elizabeth.boyle@gmail.com

Personvernombudet for forskning

Prosjektvurdering - Kommentar

Prosjektnr: 61060

VURDERING AV PROSJEKTET ETTER NY PERSONOPPLYSNINGSLOV (GDPR)

Den 20. juli trer EUs personvernforordning, samt den nye norske personopplysningsloven, i kraft. Prosjektet ditt er imidlertid vurdert etter dagens personopplysningslov, ettersom prosjektet ble meldt inn før det nye regelverket begynner å gjelde. Etter dagens lovverk har ditt prosjekt behandlingsgrunnlag i samtykke, jf. personopplysningsloven § 8 første ledd, og er vurdert av personvernombudet med hjemmel i personopplysningsloven § 31. Vi har i tillegg vurdert at, med de forslåtte endringene og tilpasningene (se nedenfor), informasjonsskrivet og samtykkeskjemaet ditt vil fylle kravene til et informert samtykke også etter det nye regelverket. Det er derfor vår oppfatning at du vil ha gyldig behandlingsgrunnlag i utvalgets samtykke når det nye regelverket trer i kraft 20. juli, da i medhold av personvernforordningen artikkel 6 nr. 1, bokstav a).

INFORMASJON OG SAMTYKKE

Dere har opplyst i meldeskjema at utvalget vil motta skriftlig og muntlig informasjon om prosjektet, og samtykke skriftlig til å delta. Vår vurdering er at informasjonsskrivet til utvalget hovedsakelig er godt utformet, men vi ber om at følgende tilføyes:

- at det er ønskelig å ta lydopptak under intervjuene
- hvem som skal ha tilgang til personopplysninger, og hvilke opplysninger de får tilgang til
- at prosjektslutt er 23.12.2018 og at innsamlet datamateriale anonymiseres innen denne datoen

Den nye personvernlovgivningen stiller skjerpede krav til informasjon og samtykke. For å imøtekomme disse endringene skal det gjøres enkelte tilføyinger i informasjonsskrivet:

- at samtykke er det lovlige behandlingsgrunnlaget for behandling av personopplysninger

- hvilke tiltak dere gjør for å sikre at ikke uvedkommende får tilgang til personopplysningene
- kontaktopplysninger til institusjonens personvernombud
- at prosjektet er meldt til Personvernombudet for forskning ved NSD (personvernombudet@nsd.no, 55 58 21 17)
- at deltakerne har rett til å sende klage til personvernombudet eller Datatilsynet angående behandlingen av personopplysninger

På våre nettsider finnes en ny mal for informasjonsskriv vi anbefaler at det tas utgangspunkt i: http://www.nsd.uib.no/personvernombud/hjelp/informasjon_samtykke/informere_om.html

Vi ber dere om å sende det reviderte informasjonsskrivet med samtykkeerklæringen til personvernombudet@nsd.no. Husk å oppgi prosjektnummer. Prosjektet kan deretter starte.

METODE

I meldeskjemaet er det krysset av for at personopplysninger vil innhentes via personlig intervju, gruppeintervju og deltakende observasjon. Personvernombudet legger til grunn at det kun innhentes personopplysninger i intervjuene, og at eventuelle registreringer under deltakende observasjon skjer anonymt. Grunnen til dette er at det ikke går fram av informasjonsskrivet hvilke opplysninger som eventuelt innhentes gjennom andre metoder. Hvis det likevel blir aktuelt å samle inn personopplysninger via deltakende observasjon, må dere inkludere informasjon om dette i informasjonsskrivet og sende utfyllende informasjon til personvernombudet@nsd.no.

INFORMASJONSSIKKERHET

Personvernombudet forutsetter at dere behandler alle data i tråd med NLA Høgskolen AS sine retningslinjer for datahåndtering og informasjonssikkerhet. Vi legger til grunn at bruk av privat pc er i samsvar med institusjonens retningslinjer.

PROSJEKTSLUTT OG ANONYMISERING

Prosjektslutt er oppgitt til 23.12.2018. Det fremgår av meldeskjemaet at dere vil anonymisere datamaterialet ved prosjektslutt.

Anonymisering innebærer vanligvis å:

- slette direkte identifiserbare opplysninger som navn, fødselsnummer, koblingsnøkkel

- slette eller omskrive/gruppere indirekte identifiserbare opplysninger som bosted/arbeidssted, alder, kjønn- slette lydopptak

For en utdypende beskrivelse av anonymisering av personopplysninger, se Datatilsynets veileder:
https://www.datatilsynet.no/globalassets/global/regelverk-skjema/veiledere/anonymisering-veileder-041115.pdf

*Author's note: Original project name redacted in NSD documentation due to risk of potential identifying information.

Appendix 3*

Informert samtykkeskjema for de som har lyst til å delta i forskningsprosjektet

«Vi lærer recovery»?

Informert samtykkeskjema for 'student' i █ Recovery Skole

Informert samtykkeskjema for 'lærer' i █ Recovery Skole

Informert samtykke for 'deltaker i planleggingskomiteen' █ kommune

I dette skrivet gir vi deg informasjon om målene for prosjektet og hva deltakelse vil innebære for deg.

Formål

Studiet vil diskutere ulike sider ved 'Recoveryskole- modellen' og ta for seg ulike perspektiver på forbedring slik dette kommer til uttrykk blant de involverte.

█ kommune satser på «recovery» som strategi i sine tjenester, der brukermedvirkning og erfaringskompetanse er sentralt i oppbyggingen av tiltak for og med målgruppa «mennesker med utfordringer innen psykisk helse og/eller rus.». Satsing på utdanning for bedring er ett av flere tiltak under utvikling som er banebrytende i norsk sammenheng.

Hvem er ansvarlig for forskningsprosjektet?

Mastergradsprosjekt v/ Rose Boyle, NLA Høgskolen (Masteroppgave i interkulturell forståelse) i samarbeid med █ Kommune

Veileder for masteroppgaven: Marit Brendbekken, NLA Høgskolen

Kontakt i █ Kommune: █

Hvorfor får du spørsmål om å delta?

Du blir invitert til individuelt intervju og/eller fokusgruppeintervju på grunn av ditt engasjement i og dine kunnskaper og erfaringer med ██ kommunes satsing på «██ Recovery College», heretter kalt Recoveryskolen.

Hva innebærer det for deg å delta?

- Hvis du velger å delta i prosjektet, innebærer det at du skal delta i et intervju med forsker. Du blir spurt om ditt engasjement i Recoveryskolen og evt. andre recovery-orientert tjenester i lokalen. Det er ønskelig å ta lydopptak av intervju med tanke på at transkripsjonen skal bli så korrekt som mulig.

- Det er mulig at forsker/veileder skal ha tilgang til personopplysninger i løpet av både personlige intervju og fokusgruppeintervju – spesifikt i forhold til navn, kjønn, alder, bosted, yrke. Den eneste opplysningen som skal samles inn etter intervju har blitt gjennomført er navn (som skal endres til en pseudonym i forskningen), og hvilken type rolle man har hatt ved å bygge Recoveryskolen, evt. om de deltok i en klasse på skolen som student, eller lærer osv.

Det er frivillig å delta

Det er frivillig å delta i prosjektet. Hvis du velger å delta, kan du når som helst trekke samtykke tilbake uten å oppgi noen grunn. Alle opplysninger om deg vil da bli anonymisert. Det vil ikke ha noen negative konsekvenser for deg hvis du ikke vil delta eller senere velger å trekke deg.

- Alle intervjuede vil bli anonymiserte og forsker har taushetsplikt.
- Alt transkribert materiale vil gjøres tilgjengelig for deltagerne.
- Eventuelle intervjuer vil bli tilsendt for gjennomlesning av den enkelte som vil få anledning til å kommentere/korrigere.
- Samtale, individuelle intervju eller fokusgruppe-intervju vil vare ca. 1 t.
- Du kan få tilsendt spørsmål på forhånd

- Det er ikke nødvendig å bestemme seg for om du skal delta i forskningen eller ikke i dag. Det er heller ikke nødvendig å delta i forskningen i hele tatt fordi du skal på Recoveryskolen i løpet av høsten 2018.
- Du kan trekke tilbake samtykket på hvilket som helst tidspunkt
- Din eventuelle deltagelse skal ikke ha innflytelse på din situasjon som student eller som ansatt.

Ditt personvern – hvordan vi oppbevarer og bruker dine opplysninger

Vi vil bare bruke opplysningene om deg til formålene vi har fortalt om i dette skrivet. Vi behandler opplysningene konfidensielt og i samsvar med personvernregelverket.

Det er mulig at forsker/veileder skal ha tilgang til personopplysninger i løpet av både personlige intervju og fokusgruppeintervju – spesifikt i forhold til navn, kjønn, alder, bosted, yrke.

Hva skjer med opplysningene dine når vi avslutter forskningsprosjektet?

Prosjektet skal etter planen avsluttes 23.12.2018 og alle opplysninger skal anonymiseres innom den datoen.

Dine rettigheter

Så lenge du kan identifiseres i datamaterialet, har du rett til:

- innsyn i hvilke personopplysninger som er registrert om deg,
- å få rettet personopplysninger om deg,
- få slettet personopplysninger om deg,
- få utlevert en kopi av dine personopplysninger (dataportabilitet), og
- å sende klage til personvernombudet eller Datatilsynet om behandlingen av dine personopplysninger.

Hva gir oss rett til å behandle personopplysninger om deg? Vi behandler opplysninger om deg basert på ditt samtykke.

På oppdrag fra NLA Høgskolen har NSD – Norsk senter for forskningsdata AS vurdert at behandlingen av personopplysninger i dette prosjektet er i samsvar med personvernregelverket.

Hvor kan jeg finne ut mer?

Hvis du har spørsmål til studien, eller ønsker å benytte deg av dine rettigheter, ta kontakt med: NLA Høgskolen ved veileder for masteroppgaven: Marit Brendbekken marit.brendbekken@nla.no

NSD – Norsk senter for forskningsdata AS, på epost (personverntjenester@nsd.no) eller telefon: 55 58 21 17.

Med vennlig hilsen

Prosjektansvarlig (Masterstudent) Rose Boyle, NLA Høgskolen
rose.elizabeth.boyle@gmail.com

(Forsker/veileder) Marit Brendbekken

Samtykkeerklæring

Jeg har mottatt og forstått informasjon om prosjektet 'Vi lærer recovery', og har fått anledning til å stille spørsmål. Jeg samtykker til:

- ☐ å delta i et personlig intervju
- ☐ å delta i en fokusgruppe om det er aktuelt

Jeg samtykker til at mine opplysninger behandles frem til prosjektet er avsluttet, ca. 23.12.2018.

(Signert av prosjektdeltaker, dato)

*Author's note: sensitive information including place names and given names of individuals, et cetera, have had to be redacted from this version.

Appendix 4

Intervju-guide for planleggere, tilretteleggere og lærere

Jeg går utfra i at Bugard kommune har arbeidet recovery-orientert i en årrekke allerede. Kan du fortelle litt, fra ditt perspektiv om hvordan dette arbeidet med å gjøre de tjenestene recovery-orientert har vokst fram?

Har det vært for motstand mot reformene og tiltakene å inkorporere brukerstemmen i Bugard kommune sine tjenester? Om det har vært noe motstand, hva mener du at dette har dreiet seg om?

Hvordan har det vært å planlegge for eller MED mennesker med svært forskjellige bakgrunn og erfaring i forhold til bedringsprosesser/recovery prosesser?

I din profesjonelle rolle som (rolletittel), hva er det særlig arbeidet ditt dreier seg om, og i forhold til recoveryskolen? Hva er det du jobber med som er forskjellig?

Jeg går utfra at du har snakket med mange brukere i rollen som (rolletittel). Hvordan oppfatter du/fra ditt perspektiv, hva mener du at Bugard kommune sine tjenester oppleves av brukere? Er de så recovery-orientert som kommunen ønsker?

I lys av måtene som Bugard kommune har arbeidet recovery-orientert, hva er det Bugard recoveryskolen tilbyr som skiller seg spesielt ut/som er annerledes/gjør en forskjell, fra ditt perspektiv?

Hvordan tror du at dette (brukerorientering osv.) har påvirket innholdet?

Hvilken rolle spiller recoveryskolen i forhold til de andre recovery-orienterte tilbudene her i Bugard kommune?

Hvordan ser du forskjellen mellom Nottingham/andre modeller og hva brukerne har utviklet i samarbeid med Bugard kommune? Har det vært noen store endringer i programmet som kommune har utviklet?

Brukergruppen som er aktuell for recoveryskolen for recoveryskolen for framtiden trolig vil være etnisk blandet. Og det har jo vist seg i forskning at det er utfordringer for de som er ikke etnisk norske for å bli fanget opp av hjelpeapparater. Hvordan vil recoveryskolen og andre recovery-orienterte tjenester i kommunen arbeide for å fange opp disse? Har man tenkt på de som er ikke etniske norske i forbindelse med planleggingen av skolen? Hvordan er dette i vår etat i Nottingham-modellen?

Oppfølgingsspørsmål:

- Hvordan kommer folk (generelt) til å bli fanget opp i recovery-skolen? Hva er plan for eventuelle reklamering av skolen?
- Hvordan vil skolen evalueleres?

Notes

[1] Representatives from the municipality and the specialist services had visited the Nottingham conference two years prior (among other international locations) and this was a deciding factor in using specifically the Nottingham as a starting model. Cooperation and planning between the municipality and Helse Vangen on the project began after the project was grounded politically and the central board of developers was formed.

2 Salutogenesis is a concept that aims to focus on factors that assist in health and wellbeing, rather than factors that are linked to poor health and illness (pathogenesis). The aim is to investigate what types of factors relate to individuals' abilities and resources towards managing stress, for example, and stay healthy rather than become ill. Rather than viewing illness as a dichotomous experience of wellbeing versus unwellness, salutogenesis aims to view the relationship between factors in life such as experience of stress, illness and wellbeing as a dynamic continuum. (Langeland & Vinje, 2014: 11-12). Other studies have also demonstrated that the degree of stress experienced by individuals is reliant on both the individual's consideration of the situation or stressor and consideration of their own personal resources for handling the situation or stressor, with these having a dynamic relationship (cf. Ogden, 2007, in Jagmann, 2012).

3 CHIME is a conceptual framework for mental health recovery developed in Scotland and is an acronym for "Connectedness – Hope and Optimism – Identity – Meaning – Empowerment" (Scottish Recovery Network, 2019).

4 The term "*mastersyke*" or "master sickness" is often used both in research around work and employment in popular media to describe the increasing numbers of students undertaking masters' degrees, as well as more employees and types of jobs requiring masters' level qualification than before (Frøjd, 2019).

[5] Døving defines what is meant by an effectively multicultural society and multiculturalism: "[multicultural society] includes different cultures, a multiculturalist society has additionally self-awareness and politics that looks after its diversity" (Døving, 2009:7).

[6] For example, Manson (1997) found that certain standardised tools for measuring mental illness were ineffective or problematic in encounters with certain native American groups, due to differences in linguistic classification of symptomatic experiences that would correspond to the white American diagnosis of mental illness. Use of certain substances as cultural ritual was often categorised with other types of substance dependence in surveys, and questions very often failed to consider culturally relevant measures of social life and wellbeing (Manson, 1997).

7 Recovery-oriented focus within guidelines, recommendations and structural plans has been a product of the last few years within mental health and drug treatment services. Some of the key papers have been: Sammen om mestring, veileder for de psykiske helsetjenestene (Helsedirektoratet 2014): «Recovery og brukermedvirkning bør prege all tjenesteyting»; Opptrappingsplanen for rusfeltet (2016-2020) (Helse og omsorgsdepartementet 2015) ; HelseOmsorg21, Nasjonal forskning og innovasjonsstrategi, (Helse og omsorgsdepartementet 2015)

«Satse på å få inn brukerperspektivet og ansette erfaringskonsulenter» ; Stortingsmelding 11, (2015-2016): «styrke brukerperspektivet ved å systematisk ansette personer med egenerfaring i tjenestene».

[8] See previous note.

9 NPM reforms in Norway began in earnest in the mid-1990s in Norway under a centre-right government, emphasising structural devolution and setting in motion partial privatisation of many large government-owned agencies, and a reform of the hospital system began in 2002 meant that the state government assumed ownership of regional health providers but delegated authority to these providers, through a combination of non-NPM and NPM style reforms (Bjurstrøm and Christensen, 2017, 2017:155-156).

10 Rejections were twice as high for individuals seeking mental health assistance as those presenting with physical complaints, and Holman (2017) blames political motivations around reducing waiting times for specialist health services as a cause for increased rejections. The likelihood of being rejected for treatment by the specialist health system was found to be double for those with a mental health issue as for those with orthopaedic or other physical complaints, and patients with a physical condition were usually at least investigated by a specialist through a consultation first. There were also regional differences, in some regions only two percent of psychiatric referrals were rejected, in others, almost 47% (Storvik, 2015). Up to 54% of general practitioners reporting they felt that DPS did not take their referrals seriously enough (Holman, 2017). On average, the psychiatric health services reject around 30% of referrals they receive without consultation, report Storvik (2015) and Holman (2017).

11 In some cases, there is a clear gap between policy and law, and the experience of patients. Electroconvulsive therapy is strictly regulated in Norway and requires patient consent, yet a 2018 report stated it has been administered on several patients in recent years without adequate consent, described in those cases as necessity (Råd for psykisk helse, 2018). However, psychologists, although arguably not in any way 'low' on the rungs of the hierarchical ladder, advocated the least for forceful measures. This study also demonstrated that in many cases, particularly among psychiatrists, respondents advocated for measures that are illegal under Norwegian law, although the respondents were not explicitly informed which of the listed options they could choose were illegal or legal (Aasland et al., 2018). Overall, the profound difference in attitudes between psychologists and psychiatrists may reflect "professional-historical equalities" that have emerged as psychology and non-clinical mental health treatment has become more commonplace, and some local "treatment cultures" may be more focused on either psychology or psychiatry. Concerningly, mental health professionals seem in many cases in disagreement with or willing to act in direct conflict with laws concerning use of force (Aasland et al., 2018).

12 Representations in media and social policy around mental illness, contributing to overall public perceptions and fears around the misconception that mentally ill individuals are violent has been categorised by some authors as a moral panic (Stickley and Felton, 2006). However, these fears are based on a misconception: individuals with mental health difficulties are far more likely to be the victims of crime than the perpetrators (Stickley and Felton, 2006). Alcohol and substance dependence are more likely indicators of violent behaviour, but as Slade argues, more socially acceptable practices such as drinking in bars are less popular targets for political change in the discussion around reducing violence risk than the mentally ill (Slade, 2014:177). Positive

risk-taking involves taking on new challenges and stepping out of one's comfort zone in order to aid personal and social recovery (Slade, 2014:176-178, Stickley and Felton, 2006). Assessments of risk carried out by service providers which stress compliance and control go against the nature of the recovery perspective, which suggests that health professionals cannot "do" recovery to someone else, or "provide" recovery services that they think best to a service user, the service user is in control (Stickley and Felton, 2006). Shepherd et al. (1995) in Stickley and Felton (2006) argued service users are often more concerned with finding an income and establishing a social network, among other elements of social and personal recovery, versus the prioritising of risk management and monitoring of clinical state by professionals. Both Slade (2014:178) and Stickley and Felton (2006) emphasise that concerns about risk as arguments against recovery perspectives reflect tensions arising from the shift in power dynamics and resulting cultural change between service provider and user in the movement towards recovery-oriented systems.

13 In a historical context, ideas about supernatural forces from Christianity predominated pre-psychiatric medicine's conception of mental illness, as many believed that symptoms of mental illness were caused by demonic influence (Martin, 2015:123).

14 Research on recovery and mental health directly draws upon Bourdieu's concept of capital, such as in Yates, Holmes and Priest (2011) and Klevan et al. (2018:17-18) who discuss the concept of "recovery capital" as a contextual frame for lived experience with mental health/substance dependence challenges. Tew (2012 in Klevan et al. 2018:17-18) argues that it "…provides a frame for developing a systemic oversight over a person's resources and strengths, and what is required in order to support a person on the journey ahead." They believe that recovery capital is a useful frame for the kind of recovery support available through the partnership between experienced-based competence, education-based competence and service users (Klevan et al., 2018).

15 Klevan et al (2018) point to examples within the substance dependence field in Norway, where employees with lived experience as substance users have been included in a variety of treatment services along with more long-established methods such as the 12-step model, which in itself is essentially recovery focused, since the 1960s and at other stages during the development of the mental health system. The policy document Opptrappingsplanen for psykisk helse (1998) was key specifically for acknowledging the value of the inclusion of employees with lived experience of mental health difficulties within the system, and particularly for recognising at an official level the equal weight of experience competence with theory-based competence.

16 Norwegian statistics suggest up to seventy percent of individuals in treatment for substance disorders can be affected by a mental health issue and suggest that there is reasonable evidence to state that both substance use and mental health disorders influence each other's development in individuals (Reneflot et al, 2018:103). The reality is likely that there is more overlap than research is able to show, and that many more individuals with mental health disorders have been affected in some way by illegal or legal substance use than is necessarily present in statistics, and vice versa (Landheim et al., 2016:33-35).

17 The district psychiatric centre (*distriktpsykiatrisksenter*) that offers generalised services within the psychiatric health field in each specific local area in Norway.

[18] This can be rented at a low price in the local area, through neighbourhood associations who have reached an agreement with the municipal authorities for the use of land.

[19] Here are some examples gathered from the feedback sheets (translations mine):
I would wish for more practical examples.

[I chose this course because] I wanted to learn more about myself, but also meet people and be social.

I chose this course because of the theoretical content and social arena.

I have learnt to say no to difficult things.

Very good teachers that ensured a safe arena, good atmosphere and ability to share.

I work voluntarily in the drug environment and I hope to [use what I have learnt] to inspire others and promote that change is possible.

Learn more about recovery and learn more about myself, my feelings and thoughts to better help others.

These are people where some have a large requirement for a lifestyle change [ex-drug addict, overweight or sedentary types]. The level of competence is quite varying understandably, but we are quite alike in requiring lifestyle change. The course should reflect this.

Body positivity could also feature more prominently in the course, not necessarily as its own subject but throughout in a more general sense.

I would appreciate less focus on bodily functions, muscle groups and food types and more practical guidance, for example using the school kitchen to prepare food or going to the gym/training together, which would make it more realistic to take charge going forward.

I will try to continue with the methods from this course and maybe try to investigate different ones going forward.

The methods were useful, as was to hear others talk about that they had struggled with some of the same things.

The most important [that I have learnt] is to take care of oneself and that there are many techniques available to get a better every day.

It was a wonderful togetherness and to be with others. I am not alone. [Going forward] I will continue to fight [because] I have a huge battle [and I] must be stronger to keep fighting.

I think it would be good with longer courses, in order to go more in depth, but also because of the chemistry that came up in the group. [However] four weeks is a good start.

What I’ve learned since starting here is the importance of food for physical and mental health.

I would appreciate more group assignments.

20 The term that was ultimately decided on for use was *samtale*, or conversation, rather than *intervju* (interview). In several meetings, right up until the final meeting before the summer break in 2019, it was a point of contention, often between 'experts by education' and 'experts by experience' over which term was more appropriate. The conversation was designed to be an interview in essence, but framed as an informal chat, to assess a potential student's suitability, ascertain whether they had chosen the course on their own agency or whether they were 'pressed' into taking a course by a caregiver or health professional, for example; and as one 'expert by education' put it in a board meeting, *"See that we are on the same side when it comes to thinking about recovery, and see that they [potential student] have come a few stages along in their own recovery process first"*.