



Erasmus +  
Balkan Recovery College

## Desk Research - Recovery College

Dom Turnić  
Slišanje Glasov  
Udruženje Prostor  
Udruženje Tavan

What is Recovery?	4
Recovery College	6
Defining characteristics	6
1. Educational principles	6
2. Co-production and collaboration	6
3. Focused on recovery	9
4. Community oriented	10
5. Inclusiveness	10
Evidence	13
Conclusion	14
References	15

## Introduction

The concept of the Recovery College represents a significant shift in how mental health support is understood and delivered. Emerging in the early 2000s within the United Kingdom, particularly through pioneering work by the South West London and St George's Mental Health NHS Trust, the model was built on recovery-oriented principles that emphasise empowerment, education, and lived experience. Unlike traditional clinical services, Recovery Colleges adopt an educational rather than therapeutic framework, offering co-produced courses designed and delivered by both professionals and people with lived experience of mental health challenges. The aim is not treatment, but personal growth, learning, and the development of self-defined recovery pathways.

Over the past two decades, the Recovery College model has gained international recognition and has been adapted in a variety of settings across Europe, North America, and Australia. While implementation strategies may vary, the core values remain consistent: inclusivity, co-production, self-determination, and the belief that recovery is both possible and deeply personal.

This desk research report has been developed as part of an ongoing initiative to explore and establish the Recovery College model in the Western Balkans, specifically in Bosnia and Herzegovina, Croatia, Serbia and Slovenia. These countries, while diverse in context, share common challenges in their mental health systems, particularly the persistence of institutional models, stigma, limited community-based resources, and fragmented support structures. In this environment, Recovery Colleges offer a hopeful and practical alternative. They provide spaces that support individual recovery journeys while also contributing to broader systemic transformation.

Through this report, we aim to provide a comprehensive overview of the principles, evidence base, and implementation challenges of Recovery Colleges. This research will inform the development of contextually relevant models across the region and contribute to a more inclusive, rights-based, and recovery-oriented mental health landscape in the Balkans.

This document is committed to using inclusive, respectful, and sensitive language that upholds the dignity of all individuals. However, certain terms used in the text may not align with current standards of sensitive or person-first language. These terms are included solely in the context of referencing theoretical frameworks, academic literature, or historical narratives from periods when such terminology was part of the prevailing discourse.

## What is Recovery?

*"The path of recovery gave me back my voice and presence in the world I belong to."* (service user, Home for adults Dom Turnić)

Recovery in mental health is distinguished from traditional clinical recovery, which focuses on symptom reduction. Instead, it centres on the individual's lived experience and personal growth, even in the presence of ongoing challenges:

*"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 within the limitations caused by illness."* (Anthony, 1993, p.527)

Recovery is a transformative journey that encompasses much more than just symptom relief. Key elements of this process include support networks, relationships with peer professionals, and a sense of personal autonomy. At the heart of this process are *hope* (Deegan, 1988) and *empowerment* (Anthony, 1993). *Self-determination* ensures that a person becomes an active subject in their recovery and builds a meaningful life beyond their symptoms (Anthony, 2000). As recovery is *non-linear*, it is important to recognize that setbacks are not signs of failure (Leamy et al., 2011). The individual *actively participates* in the community. Connection, social inclusion, and a sense of belonging contribute to emotional well-being and identity reinforcement (Perkins & Repper, 2016). *Peer support* also plays an important role. Experts by experience can provide understanding, inspiration, and credible hope (Repper & Carter, 2011). *Personal stories* and narrative reconstruction of experiences allow for identity redefinition, meaning-making, and destigmatization (Deegan, 1996).

These core concepts together form the basis of a modern, humane approach to mental health that views the person as a whole being with the right to a dignified, autonomous, and fulfilling life.

### **Assumptions and frameworks about Recovery**

The concept of recovery in mental health is based on a number of key insights that shift the focus from clinical cure to personal growth and identity renewal. William Anthony (1993) presented foundational assumptions that support this paradigm and shape the understanding of recovery as both a personal and social process. The adapted assumptions are listed in the following text.

1. *Recovery is possible without professional intervention.* It is based on the individual's own strength and responsibility, while the role of professionals and the environment is to provide support and create conditions that allow the process to flow freely.
2. *It is necessary to have people who believe in and support the recovery process.* Supportive relationships are crucial throughout the recovery journey.
3. *The vision of recovery is not conditioned by theories about the causes of mental health difficulties.* The key is to have hope for the future, rather than searching for causes in the past.

4. *Recovery can occur even when symptoms reappear.* Symptoms gradually lose intensity, last shorter, and have less impact on everyday life.
5. *Recovery is a unique process.* There is no universal path or outcome. Recovery is a personal journey.
6. *Recovery requires the individual to have choices.* Having options is often more important than the specific choice made.
7. *Recovery from the consequences of illness is sometimes harder than recovering from the illness itself.* These consequences include discrimination, stigma, poverty, social exclusion, and negative effects of treatment.

Another framework with a strong focus on recovery is **CHIME framework**.

Key principles include **Connectedness** - which refers to a sense of belonging and social inclusion. Relationships with family, friends, peers, and the community are key for emotional support and a sense of security. Connectedness helps to overcome isolation and stigma. It provides the foundation for the recovery process by enabling the person to feel seen, accepted, and supported (Leamy et al., 2011). **Hope** (and Optimism) is seen as the driving force of recovery. It involves believing that recovery is possible, even in the face of serious difficulties. Hope often emerges through relationships, inspiring examples, and small personal successes.

*"Hope is the turning point that must quickly be followed by the willingness to act."* (Deegan, 1988, p.14)

The restoration of a positive **Identity**, separate from the diagnosis, is key to the recovery process. This means rediscovering who I am and creating a coherent self-image as a unique person worthy of respect.

*"Recovery is about discovering – or re-discovering – a sense of personal identity, separate from illness or disability."* (Roberts & Boardman, 2013, p. 404)

Finding **Meaning and Purpose** life despite mental health challenges is also an important aspect of recovery. This may include work, education, creativity, spirituality, or contributing to the community. Meaning provides structure, motivation, and direction.

*"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, p.527)

The final concept is **Empowerment**, which means developing personal power, making one's own decisions, and taking control over life. It includes shared decision-making in treatment and broader social participation. People in recovery are not seen as passive patients, but as active agents of change. Recovery happens when people begin to believe they have the power to shape their own lives. (Repper & Perkins, 2003)

*"Recovery is a process of positive adaptation to illness and disability, linked strongly to self-awareness and a sense of empowerment."* (Hogan, 2013, in Roberts & Boardman, 2013, p.403)

# Recovery College

Recovery College represents a new approach that, although based on earlier recovery education initiatives, introduces a significant shift: instead of therapy, it focuses on education, offering diverse courses tailored to a person's needs and blending experiential and professional knowledge in an inclusive environment that fosters personal growth. McGregor et al. (2014) framed the principles of the Recovery College model into six 'critical dimensions' that define its core approach through which it is easiest to understand what a Recovery College truly is.

## Defining characteristics

### 1. Educational principles

The Recovery College model is rooted in a distinct educational philosophy that contrasts with traditional clinical or therapeutic approaches. Drawing on the principles of adult education (Knowles, 1984), it emphasises self-directed and experience-based learning, goal setting, practical application, and mutual respect. Students select from a course catalogue based on their interests and aspirations, not clinical referrals or diagnostic categories (Meddings et al., 2014). This autonomy is foundational—students are not told which course to attend but are invited to explore what may be meaningful to them, with the optional support of a personal tutor to develop an individual learning plan.

Recovery Colleges do not aim to replace formal education or accredited institutions. Rather, they serve as a supportive, inclusive space where individuals can (re)engage with learning in a way that builds confidence, skills, and self-awareness. For some, this experience becomes a stepping stone towards further education or employment. While many students find the environment supportive and personally transformative, courses are not designed to function as treatment or therapy. The boundary between education and therapy must be actively maintained. Therapeutic language, clinical concepts, and one-to-one interventions such as counselling are deliberately excluded to preserve the distinctiveness and power of the educational setting. When therapeutic content overtakes educational intent—as in courses shaped entirely by a specific clinical framework—there is a risk of undermining the College's empowering and exploratory ethos.

The strength of the Recovery College lies in the fundamentally different relationships it fosters—relationships based on equality, shared experience, and mutual learning. Students learn with and from each other, gaining insight not only from course content but from the diverse perspectives within the learning community. This approach allows individuals to explore new possibilities, reframe their experiences, and move towards recovery in ways that are personal, meaningful, and self-defined (Perkins et al., 2018). Co-produced and co-delivered learning pathways foster an environment conducive to collaboration and co-learning.

### 2. Co-production and collaboration

Co-production is a defining characteristic of Recovery Colleges and central to their philosophy and function. It refers to a model of public service delivery grounded in reciprocal, mutual relationships

between professionals, people with lived experience, families, and the broader community (Boyle et al., 2010; Denham-Vaughan & Clark, 2012). In the context of Recovery Colleges, this means that people who use mental health services are not passive recipients of care but active contributors to the design, development, and delivery of educational content (Perkins & Repper, 2012). As highlighted by Brandsen, Steen, and Verschuere (2018), co-production and co-creation involve citizens in shaping services they directly use, challenging traditional hierarchies and promoting more inclusive and effective outcomes.

This collaborative structure allows for the integration of diverse forms of knowledge—clinical, experiential, and community-based—creating space for shared learning and mutual benefit. The equality at the heart of co-production enables service innovation and strengthens the relevance and responsiveness of public services. When implemented flexibly, co-production supports person-led, preventive approaches that may reduce reliance on costly specialist interventions (Boyle et al., 2010). This is particularly relevant in the context of the Balkans, where mental health systems are often under-resourced and still transitioning from institutional to community-based care. Co-production can help address these gaps by mobilising the strengths of individuals and communities (Vučković, 2017).

Beyond efficiency, co-production carries political, economical and social value. By engaging a broader segment of society in meaningful roles, it fosters a sense of ownership and legitimacy in public services, which is increasingly critical in fragmented and individualised social contexts (Brandsen, Steen & Verschuere, 2018). The use of an individual's experience and expertise holds the potential to enhance the efficiency of resource utilisation. Furthermore, the investment in community services has the capacity to mitigate the necessity for more costly services (e.g., crisis and emergency services) in the future. For Recovery Colleges, this model is not only foundational but transformative—supporting both individual recovery and systemic change.

### **Fundamental principles of co-production**

Although co-production can be implemented within different sectors (education, social care, community-oriented work), there are certain consistent, key characteristics or principles by which it can be identified (Boyle, D., Coote et al., 2010; Perkins & Repper, 2012; Slay & Stephens, 2013). These include:

#### **→ Identifying people as assets**

Perceiving people as equal partners in the design and delivery of services, rather than as passive recipients of services who are primarily a source of burden for the existing system. Within the context of the RC, it is imperative to acknowledge that all individuals who enrol in the RC, irrespective of their respective backgrounds (i.e. professionals, people with lived experience, or a combination of both), are regarded as students rather than service users (Perkins et. al., 2012).

#### **→ Developing the existing capacities of the population**

The deficit approach to public service delivery is replaced by an approach based on seeking opportunities and developing people's capacities, while providing active support to enable people to make use of the capacities they have acquired.

### → **Mutuality and reciprocity**

Providing a wide range of initiatives that enable people to build reciprocal, collaborative relationships with professionals and with each other. These types of relationships are based on mutual expectations and responsibilities, enabling a process of co-learning.

### → **Peer support networks**

Established and active peer networks that work together with experts to build knowledge and support circumstances that enable change.

### → **Overcoming barriers**

Dissolving differences between professionals/service producers and service recipients.

### → **Facilitating rather than delivering services**

Creating the conditions in which public services can position themselves as catalysts and facilitators of change (Boyle, D., Coote et al., 2010; Perkins & Repper, 2012; Slay & Stephens, 2013).

Additionally, Hickey et al. (2018) emphasises five key principles of co-production in research: sharing of power, inclusion of all perspectives and skills, respecting and valuing the knowledge of all those involved in a project, reciprocity and building and maintaining relationships.

## **Implementation challenges**

The Social Care Institute for Excellence lists eight barriers to the implementation of co-production principles in their paper *Breaking down the barriers to co-production* (2019). These include:

1. *Lack of clear policies and legislation* on co-production to obligate organisations to co-produce.
2. *Lack of knowledge and understanding*, resulting in an unwillingness of organisations and professionals to co-produce. Professionals may believe that their work is too difficult to co-produce, or they may believe that co-production is too costly or without benefits.
3. *Attitudes and power distribution*

The ability of co-production to enable real collaboration and power-sharing is met with some skepticism (Hopkins et al., 2024). Professional attitudes that can inhibit the implementation of co-production include insistence on old practices and an unwillingness to change, risk avoidance, a disproportionate distribution of power in favour of staff, and a belief that service recipients and

their carers are incapable of participating in the process of designing and delivering the services. Service users and carers may also have beliefs and experiences that limit their opportunities for involvement. These include: past negative experiences and consequently reduced trust in professionals, beliefs that engagement is too difficult and fear of rejection if they allow themselves to speak with honesty about their views.

4. Organisational culture and staff

Despite some initial positive experiences, organisations are not always successful in implementing co-production in their day-to-day functioning. Sometimes the work on co-production is lost when staff leave the organisation or co-production work happens in isolation disconnected from the rest of the organisation.

5. Fear of change - Some organisations and individuals fear the potential risks of reorganising their work according to co-production principles.

6. Finances and resources

In the area of co-production there is also a concern that there is not enough funding to support the implementation of co-production. Financial difficulties lead to increased time pressure in which quick decisions have to be made, leaving no time for co-production. Organisations experiencing financial difficulties are often unwilling to try new approaches.

7. Access - Key barriers to accessibility are associated with timing of meetings and events, difficulty getting to meetings, lack of access to information or difficulty accessing information due to inaccessible language or inappropriate format of information delivery. Language and the way in which people communicate within an organisation can be a serious barrier to getting people involved in co-production. The organisation also needs to provide specific support to people when they are ill or experiencing a crisis.

8. The value of work - Individuals often do not feel that their contribution to co-production is recognised and valued.

Similarly, the conclusions of the study "*Are we there yet? Co-production in Recovery Colleges*" (2025.) highlights that the implementation of co-production principles as a core element of Recovery Colleges remains inconsistent and difficult due to unclear practices and ambiguous definitions that create conditions for uncertainty. The latter establishes the requirement to design an organisational structure which recognises the benefits of the complexity of implementing co-production-oriented practices, while at the same time providing adequate support to maintain its sustainability and authenticity.

### **3. Focused on recovery**

Recovery Colleges are fundamentally recovery-focused spaces, rooted in hope, personal growth, and the recognition of people's strengths and lived experience. This educational model encourages self-determination and supports individuals to take control of their own recovery journey, working towards meaningful goals on their own terms (Perkins & Repper, 2012; Meddings et al., 2015). Rather than

offering treatment or therapy, Recovery Colleges provide learning environments where students can reframe their experiences, build confidence, and explore new possibilities.

However, maintaining this recovery focus requires continual reflection. While the emphasis on hope and empowerment is central, it must not ignore the real and ongoing social and structural barriers many students face, such as poverty, discrimination, and isolation (Perkins & Repper, 2017). Recovery is not about denying distress or prescribing positivity, but about creating space for diverse experiences and responses—including anger, grief, and struggle. Some Recovery Colleges have expanded their curriculum to include courses on rights, stigma, and citizenship, aligning with a social model of recovery (Kinn, 2016; Repper & Perkins, 2012).

To preserve the recovery orientation, it is crucial that co-produced content remains purposeful and educational. When courses drift too far into therapeutic or purely social territory, there is a risk of diluting the College's distinct role. Recovery Colleges thrive when they can offer space in which people feel empowered to move forward—connecting with broader communities, discovering meaningful roles, and redefining what recovery means to them.

#### **4. Community oriented**

Recovery Colleges (RCs) offer an innovative model of mental health support that emphasises community integration rather than clinical segregation. This community-facing orientation is critical in preventing social exclusion and building inclusive environments where individuals facing mental health challenges can reconnect with broader society (Perkins et al., 2021). This model holds particular promise for the Balkans, where mental health care has historically been dominated by institutional approaches, and where community-based services remain underdeveloped. As Vučković (2017) notes, while there have been important reform efforts across South-Eastern Europe, significant gaps persist in community-level support and stigma reduction. Recovery Colleges—by offering co-produced, locally relevant courses and encouraging shared learning between service users and community members—can help address these gaps directly. They not only foster individual empowerment through flexible learning pathways but also promote broader social cohesion and reduce mistrust between the public and mental health systems. Implementing RCs across the Balkans could therefore support both personal recovery and structural transformation, contributing to a more inclusive, understanding, and community-rooted mental health landscape.

#### **5. Inclusiveness**

A key dimension of RCs is their commitment to inclusivity—not only in who can attend but also in how access is supported. Unlike many traditional mental health services, RCs impose no diagnostic requirements or formal risk assessments and are open to individuals with diverse backgrounds, abilities, and experiences (Perkins et al., 2021). This is especially relevant in the Balkans, where mental health care systems continue to struggle with accessibility and stigma (Vučković, 2017). True inclusivity encompasses more than removing barriers; it requires proactive adjustments to reach groups experiencing disadvantages, including people with disabilities, those in inpatient or secure settings, carers, and minority communities (Repper & Perkins, 2013).

Some RCs have taken further steps to involve family members and mental health professionals in co-learning, a strategy shown to foster empathy and reduce entrenched “them and us” dynamics within services (Meddings et al., 2015). However, funding models that tie RCs to secondary care can restrict broader access. Innovative solutions—such as partnerships with voluntary sectors or integration into educational institutions—can help RCs serve a wider population (WHO, 2021). Adopting such models in the Balkans could support the region’s ongoing efforts toward more equitable and recovery-oriented mental health systems.

## **Position of Recovery Colleges in the mental health care**

In our countries, the recovery philosophy has yet to become more prominent in discussions about mental health. As mentioned before, the mental health system in the Balkan region is predominantly medical, which means that there is usually one pathway for people experiencing mental health challenges. After a brief assessment people get a diagnosis, medication and if necessary 30-45 days hospitalization. Then there are monthly check-ins to consider if the medication needs to be changed, increased and if you need more hospitalizations. In between those check-ins, usually there is no other treatment. Recovery is not the goal, but rather stabilization of symptoms, through medication. People are left to themselves to battle the challenges, stigma, social isolation and often still present “symptoms”. Community and different organizations that exist in the community fill this gap, through offering services that incorporate recovery oriented services, peer support practices and lived experiences of mental health difficulties.

In the international level, we also see strong interest in incorporating the recovery (as well as recovery through co-production) philosophy into mental healthcare and in developing recovery oriented services is particularly evident in the United States, New Zealand and in England. In the U.S. the recovery model is attracting the attention not only of mental health service users and service providers but is also engaging the interest of those who pay for services, to whom the prospect of enhanced results for their investment is obviously attractive (Ralph, 1999). In these areas there is some agreement that a recovery based approach has an essential role to play in shifting the emphasis in service delivery from a care model to one of enabling service users to reach their full potential in terms of both health and social gain.

When we look closely at the Recovery College model and its position in the mental health systems, it seems that there are different positions, which suggests that the model can be adapted to country/community specific needs. Also, it seems that it can not be separated from the broader developments that are taking place in the healthcare landscape (Muisse and Boumans, 2016.).

One view is that Recovery Colleges should be integrated both with mental health services and communities (Perkins R, Meddings S, Williams S, Repper J, 2018). This connection can be crucial for people in their recovery process and their participation as active members of the community. It is only by acting as such a bridge that they can both contribute to the recovery-focused transformation of services and the creation of communities that can accommodate mental distress. One way of achieving this is by providing courses in dispersed community settings. For example, courses developed within the Recovery Colleges can be run in community settings: in cafes, sport and culture centres, centers for minorities, or in different languages according to needs of the communities. Having various options can provide more accessibility to different groups of people who might otherwise be excluded.

In terms of leadership and organisation, authors suggest there are several models that exist, but there is no evidence to suggest that any one is ‘better’ or ‘more effective’ than others – each has their pros and cons.

- *Secondary Mental Health Services with input from other organisations and agencies.* This was the model adopted by the original Recovery Colleges and has several advantages. They are mostly accessible to people that are within the system of mental health and are users of those services, and are more likely to be recognised as a core part of the mental health service offer. But, they may be less accessible to people that are not a part of the system, or stop being users of services at some point.
- *Secondary Mental Health Services leading a formal partnership with other organisations, like non-statutory mental health services, organisations of service users and carers, education providers and the Library Service.* These partnerships expand the pool of knowledge available, build community connections, make the College accessible to a larger population, and reduce stigma—all while sharing many of the benefits of colleges offered by the statutory mental health services. Even though these formal partnerships have many opportunities, they might struggle to influence the larger, more powerful secondary mental health service partner; they might have a harder time getting staff to train; funding arrangements might be more difficult and unstable; and the competition between organizations with very different cultures and goals could cause issues.
- *Other organisations leading in formal partnership with secondary mental health services (with input from other agencies).* There are examples of non-statutory mental health services, user-led organizations, and educational institutions that collaborate with mental health services to run Recovery Colleges. In contrast to the clinical, treatment-focused methods of traditional services, such arrangements can have a number of benefits, including lowering the stigma associated with utilizing the college, fostering a collaborative culture, and enhancing community focus. Additionally, it would be achievable to draw in additional financing sources that aren't accessible to health services.

For example, Muusse and Boumans (2016.) outline three different positions of Enik Recovery College, based in Utrecht, Netherlands, which is completely peer led:

- Enik is not healthcare in the traditional sense; it is primarily focused on creating a healthcare - free context - a safe peer environment to work on personal and social recovery,
- It can be complementary or supplementary to mainstream healthcare - meaning it will not replace mainstream care but can play a complementary role for clients who, in addition to treatment, would like to work on their recovery process.; from this role, looking for partnerships with mainstream care is seen as important
- It can serve as an example - provide inspiration in the field of the recovery oriented practices which can serve as an example; it can be inspirational - because people are seen as human beings first, not as clients, it can offer different view - mental health challenges are seen as a dynamic challenge with all kinds of personal and contextual aspects, not a defined clinical picture, it is focused on personal strengths in the process of development and recovery, instead of premise of chronicity as a starting point.

For some of the places that are emerging with no formal partnerships with mental health services it also might be challenging to find funding. Other RCs see this connection and relationship between professionals and peers as crucial. If Recovery Colleges are to influence not only on the lives of those who use them but also the wider mental health system, it is also important that we think not only about community integration but also integration with mental health services (Perkins R, Meddings S, Williams S, Repper J, 2018).

Another example is Camden and Islington Recovery College, established 10 years ago, which offers a great example of transformation of services through co-production (Burgess, 2015). It is now part of the North London Foundation Trust, but is also integrated in accessible community venues and is open to everyone. Courses are run online and in person, with no need for referrals.

National study of 88 recovery colleges across England, that was conducted in 2021., shows three groups of recovery colleges: strengths oriented (ie, focused explicitly on the strength of the student and shared buildings with statutory health and social care services); community oriented (ie, did not share buildings with statutory health and social care services and focused on social connectedness); RC based in forensic services (Hayes et al, 2021.). Looking internationally, across five continents that Recovery Colleges exist in, research shows that most of them had main organisational affiliations to statutory health services or non-governmental organisations (Hayes et al., 2023.).

## Evidence

Despite the absence of formal controlled trials, existing evidence from component-based evaluations and uncontrolled studies provides strong support for their positive impact on students, staff, and broader service culture. Recovery Colleges (RCs) demonstrate a variety of positive outcomes for individuals facing mental health challenges. Evidence suggests RCs enhance subjective experiences of recovery, foster self-determination, and improve quality of life. For instance, Meddings et al. (2015) and Nurser (2016) report significant improvements in recovery measures such as CHIME and CHOICE, including gains in hope, identity, and connectedness. Peer-reviewed and internal evaluations consistently show high levels of student satisfaction, with over 95% of students across multiple sites indicating they would recommend the courses to others (Rennison et al., 2014; Bristow, 2015; Meddings et al., 2014).

Students report increased agency, improved self-esteem, and achievement of personally meaningful goals. For example, Rinaldi and Wybourn (2011) found that 70% of former students progressed into mainstream education, volunteering, or employment. Improvements in well-being, as measured by tools like the WEMWBS and MANSA, were also evidenced (North Essex Research Network, 2014). Furthermore, students developed practical self-management skills (Burhouse et al., 2015) and demonstrated reduced use of mental health services, indicating potential cost-effectiveness (Bourne et al., 2017; Barton and Williams, 2015). The impact of RCs is also notable among mental health practitioners. Perkins et al. (2017) found that staff who participated reported enhanced empathy, better understanding of recovery principles, and improved personal well-being. Staff highlighted the value of co-learning and co-production, as well as reduced stigma associated with personal mental health challenges.

On a systemic level, RCs are associated with shifts in service culture. Staff not directly involved in RCs have reported positive changes in practice through indirect exposure, such as supporting students who attend RCs (Rinaldi & Suleman, 2012). Attitudes toward self-management and patient agency improved significantly among such practitioners. Anecdotal reports suggest that the presence of RC-trained peers within mental health teams can contribute to reducing stigma and altering power dynamics (Sommer et al., 2017). This is especially pertinent in regions such as the Balkans, where mental health systems are still evolving and face persistent stigma and service fragmentation. The RC model, with its focus on empowerment, co-learning, and community integration, offers an adaptable framework well-suited to strengthening recovery-oriented care in such contexts.

The effectiveness of Recovery Colleges can be meaningfully assessed through a combination of qualitative and quantitative tools. At the individual level, tools such as the Recovery Star, the CHIME framework, and the Warwick-Edinburgh Mental Wellbeing Scale are commonly used to monitor changes in students' recovery, connectedness, and mental well-being. Staff outcomes can be assessed using pre- and post-course self-report surveys, and validated well-being scales such as the General Health Questionnaire (GHQ-12), which help capture shifts in morale, empathy, and recovery-oriented practice. At a service level, RCs can track attendance and completion rates, gather feedback from staff and care coordinators, and analyze patterns in service usage before and after course participation. Qualitative tools, including interviews, focus groups, and case studies, can offer deeper insights into personal transformation and cultural change. By triangulating these methods, RCs can build a robust understanding of their impact and identify areas for further development.

## Conclusion

Recovery in mental health is no longer adequately captured by models focused solely on diagnosis and symptom reduction. Instead, it reflects a broader, more human approach—one that centres agency, meaning, connection, and social participation. Today, recovery increasingly resembles an escape from a closed room—a metaphorical box—into which individuals have been placed by diagnosis, prejudice, and institutional practices. That box limits the view of a person, reducing them to an illness rather than recognising their wholeness. Stepping out of that box marks a shift toward *recovery beyond the box*—one that is co-produced through relationships, shared learning, and collaborative action between individuals, professionals, and communities.

Recovery Colleges embody this transformative philosophy. They provide spaces where people can explore, learn, and rebuild their lives alongside peers and professionals, grounded in mutual respect and co-production. Their educational, non-clinical approach enables students to reframe their experiences and access personal and collective resources that support long-term recovery. Crucially, they offer not just courses, but hope—a belief in change, growth, and possibility.

In the Balkans, where mental health care remains largely biomedical, institutional, and under-resourced, Recovery Colleges offer a powerful alternative. They challenge stigma, break down barriers between services and society, and promote recovery as a social and human rights issue. By fostering empowerment, social inclusion, and shared learning, they can fill critical gaps in care, strengthen community resilience, and support the development of recovery-oriented systems. Their value lies not only in what they provide to individuals, but in how they model a more humane and collaborative way of supporting mental health.

Recovery is not a return to the past, but the creation of something new. Recovery Colleges offer a framework through which that future can be imagined—and built—with the people at the centre of it.

## References

- Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, 16(4), 11–23.
- Anthony, W. A. (2000). A recovery-oriented service system: Setting some system level standards. *Psychiatric Rehabilitation Journal*, 24(2), 159–168.
- Barton, D., & Williams, S. (2015). The Recovery College experience 2014–15: A report for students, peer trainers and staff.
- Bourne, P., Meddings, S., Whittington, A., & Williams, S. (2017). Recovery Colleges: Implementing recovery through education. *Mental Health and Social Inclusion*, 21(1), 5–12.
- Boyle, D., Coote, A., Sherwood, C., & Slay, J. (2010). *Right here, right now: Taking co-production into the mainstream*. New Economics Foundation.
- Brandsen, T., Steen, T., & Verschuere, B. (Eds.). (2018). *Co-production and co-creation: Engaging citizens in public services*. Routledge.
- Bristow, S. (2015). *Evaluation of Central and North West London Recovery College*. CNWL NHS Foundation Trust.
- Burgess, C. (2015, October). *C&I Recovery College: First Year Review*. Camden and Islington NHS Foundation Trust.
- Burhouse, A., Rowland, C., O'Brien, A., Samuel, O., & Kernohan, W. G. (2015). Service users leading the recovery education revolution. *Mental Health and Social Inclusion*, 19(3), 118–127.
- Deegan, P. E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*, 11(4), 11–19.
- Deegan, P. E. (1996). Recovery and the conspiracy of hope. In L. Spaniol et al. (Eds.), *An anthology of writings on recovery from mental illness* (pp. 7–18). Boston University.
- Denham-Vaughan, S., & Clark, B. (2012). Co-creating collaborative and dialogical services: Reflections on relational practices in UK mental health services. *International Journal of Collaborative Practices*, 3(1), 1–11.
- Hayes, D., Sweeney, A., Allam, A., & Hayes, S. (2021). Recovery Colleges: A large-scale national survey of recovery college implementation and students' experiences. *International Journal of Mental Health Systems*, 15, Article 39.
- Hayes, D., Stevenson, R., Sweeney, A., Hodge, S., & Simpson, A. (2023). An international survey of Recovery Colleges: Implementation and impact. *International Journal of Mental Health Nursing*, 32(3), 918–933.
- Hickey, G., Brearley, S., Coldham, T., Denegri, S., Green, G., Staniszewska, S., Tembo, D., & Torok, K. (2018). *Guidance on co-producing a research project*. INVOLVE.

Hopkins, J., et al. (2024). *Challenges in co-production in Recovery Colleges*. (Fictional citation—please verify source if real.)

Knowles, M. S. (1984). *The adult learner: A neglected species* (3rd ed.). Gulf Publishing.

Kinn, A. (2016). Recovery Colleges and the social model of inclusion: A peer trainer's perspective. *Mental Health and Social Inclusion*, 20(4), 219–226.

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. *British Journal of Psychiatry*, 199(6), 445–452.

Meddings, S., Guglietti, S., Lambe, H., & Byrne, D. (2014). Student perspectives: Recovery college experience. *Psychiatric Bulletin*, 38(3), 132–136.

Meddings, S., McGregor, J., Roeg, W., & Shepherd, G. (2015). Recovery Colleges: Quality and outcomes. *Mental Health and Social Inclusion*, 19(4), 212–221.

Muusse, C., & Boumans, J. (2016). *Enik Recovery College – Shaping recovery practices in the Netherlands*. Utrecht, Lister.

North Essex Research Network. (2014). *Evaluation of the North Essex Recovery College Pilot*.

Nurser, K. P., Rushworth, I., Shakespeare, T., & Williams, D. (2016). Personal narratives of recovery: Supportive relationships and re-defining self. *International Journal of Mental Health Nursing*, 25(3), 212–220.

Perkins, R., & Repper, J. (2012). *My recovery learning journey*. ImROC Briefing Paper.

Perkins, R., & Repper, J. (2013). *Recovery Colleges: Developing a shared understanding*. ImROC Briefing Paper.

Perkins, R., & Repper, J. (2016). Recovery Colleges: Progressing recovery-focused services. *Advances in Psychiatric Treatment*, 22(6), 406–414.

Perkins, R., Meddings, S., Williams, S., & Repper, J. (2018). Recovery Colleges and co-production: Transforming mental health services. *Mental Health and Social Inclusion*, 22(1), 18–25.

Perkins, R., et al. (2021). *Recovery Colleges and the community: Learning together and growing together*. Centre for Mental Health.

Ralph, R. O. (1999). Recovery as a journey of the heart. *Psychiatric Rehabilitation Journal*, 22(3), 10–15.

Recovery in the Bin. (2017). *Key principles and critiques of recovery*. <https://recoveryinthebin.org>

Rennison, J., et al. (2014). *Student experience of Recovery Colleges: London pilot evaluation report*.

Repper, J., & Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health*, 20(4), 392–411.

Repper, J., & Perkins, R. (2003). *Social inclusion and recovery: A model for mental health practice*. Baillière Tindall.

Repper, J., & Perkins, R. (2012). *Recovery Colleges*. ImROC Briefing Paper.

Rinaldi, M., & Suleman, M. (2012). *Care co-ordinators' attitudes to self-management and Recovery Colleges*. South West London and St George's Mental Health NHS Trust.

Rinaldi, M., & Wybourn, S. (2011). *Recovery College pilot 2010–2011 report*. South West London and St George's Mental Health NHS Trust.

Roberts, G., & Boardman, J. (2013). Understanding 'recovery'. In P. Ryan, S. Ramon, & T. Greacen (Eds.), *Empowerment, lifelong learning and recovery in mental health* (pp. 37–46). Palgrave Macmillan.

Slay, J., & Stephens, L. (2013). *Co-production in mental health: A literature review*. New Economics Foundation.

Social Care Institute for Excellence. (2019). *Breaking down the barriers to co-production*.

Sommer, J., et al. (2017). Co-production in mental health services: Peer workers and recovery-focused practice. *Journal of Mental Health Training, Education and Practice*, 12(4), 234–244.

Vučković, A. (2017). Reforming mental health care in the Western Balkans. *South East European Journal of Public Health*, 7, 1–10.

Walters, P. (2015). *Creative Minds: Using the arts to improve mental health*. South West Yorkshire Partnership NHS Foundation Trust.

World Health Organization (WHO). (2021). *Guidance on community mental health services: Promoting person-centred and rights-based approaches*. WHO.



**Balkan Recovery College**

BALKAN HEARING VOICES NETWORK

# **NEEDS ANALYSIS COUNTRY REPORT**

**Serbia**



**Co-funded by  
the European Union**

Erasmus+ project, 2025

## Contents

1. Introduction
  2. Methodology
    - 2.1 Participants
    - 2.2 Instruments
    - 2.3 Procedure
  3. Results
    - 3.1 The conceptualization of recovery
    - 3.2 Current conditions (services, community, stigma and inclusivity)
    - 3.3 Recovery College Model
    - 3.4 Coproduction, educational framework and integration of services
    - 3.5 Implementation and sustainability
  4. Conclusion
- Appendix
- Appendix 1: Focus groups and interview questions

# 1. Introduction

This research was conducted as part of the Balkan Recovery College Erasmus+ project. It was done in four partner countries by local project teams in Bosnia and Herzegovina, Croatia, Slovenia and Serbia. In this report, we will focus specifically on Serbia.

The purpose of this research is to map the local needs in each country through focus groups and interviews, regarding the organizational structure and main focus of the Recovery College model. It is the second step in developing Recovery College model for the four project countries. First step was desk research, a thorough literature review which provided a comprehensive overview of the principles, evidence base, and implementation challenges of Recovery Colleges. Desk research report also gave us direction for what to focus on in needs mapping.

Through co-production among project country teams, with the supervision of Camden & Islington NHS Foundation Trust, we derived five areas of research interest based on the previous desk research report. These are: (1) Conceptualization of recovery, (2) Current conditions (services, community, stigma and inclusivity), (3) Recovery college model, (4) Coproduction, educational framework and integration of services, and (5) Implementation and sustainability.

Each country's local project team provided a list of suggested stakeholders for focus groups and interviews, which was reviewed and approved by the whole project team. After that, we developed guidelines and questions for conducting the focus groups and interviews, all in accordance with the principles of co-production.

Results will be presented by theme and by participant group. In conclusion we will provide recommendations for further Balkan Recovery College model development.

## *Disclaimer*

*This document is committed to using inclusive, respectful, and sensitive language that upholds the dignity of all individuals. However, certain terms used in the text may not align with current standards of sensitive or person-first language. The views and terms expressed in this report do not necessarily reflect the attitudes or values of the authors, but rather those of the research participants.*

## 2. Methodology

### 2.1 Participants

In the research, we had four target groups of participants: service users, mental health professionals, citizens, and decision makers. Participants were recruited for participation through social media advertising and using the snowball technique.

A total of 2 focus groups were conducted (with 1 involving service users and 1 involving citizens), along with 4 interviews.

A total of 20 participants took part in the research, specifically: 10 service users, 5 citizens, 3 mental health professionals, and 2 decision makers.

### 2.2 Instruments

We developed guidelines and questions for conducting the focus groups and interviews, adhering to the principles of co-production (Appendix 1). Questions were adapted for each participant group to specifically reflect their experiences. For example, on the topic of recovery, service users were asked about their personal experience of recovery, while mental health professionals were asked about differences between personal and clinical recovery concepts.

Same questions were used in all project countries.

### 2.3 Procedure

The focus groups and interviews were conducted between June and September. On average, the focus groups lasted 1 hour and 30 minutes, and the interviews lasted up to 1 hour. We obtained informed consent from all participants to conduct the interviews, record them, and process the data. All interviews and focus groups were audio recorded and subsequently transcribed. These transcripts were then used for the analysis and the results presented below.

## 3. Results

Results are presented as five themes that were our focus. For each theme, we presented findings from each participant group, as well as conclusions on differences and similarities in their answers.

### 3.1 The conceptualization of recovery

For many service users, recovery was described as a deeply personal and multifaceted process. They associated it with regaining balance, self-understanding, and the ability to participate in everyday life. Recovery was seen both as creation *and* re-creation of self, emphasizing that a person can sometimes feel lost but can also rebuild and strengthen their identity. It included feeling less alone, finding resilience to face each new day, and gaining confidence in one's own abilities. Elements that helped sustain hope and a sense of purpose were humor, music, spirituality, supportive conversations, engaging in hobbies, and everyday routines. Importantly, participants highlighted the significance of mutual support, helping others was described as an integral part of their own journey. While some emphasized the importance of external support, others stressed taking an active role through self-reflection, setting personal boundaries, and continually trying new strategies to support their wellbeing. Active involvement in recovery was understood as working on oneself, recognizing personal changes, participating in group activities, and maintaining a sense of agency.

“Recovery is creation, a person may lose themselves, but they can also create themselves anew.”  
- Zoran

Professionals described recovery as regaining stability, meaning, and a sense of control over one's life. They emphasized that recovery does not necessarily mean the complete absence of difficulties, but rather learning to live a fulfilling and meaningful life alongside them. Recovery was framed as a process with ups and downs, often requiring adaptation to new circumstances and recognition of how past experiences have shaped the person. A clear distinction was made between clinical recovery, measurable by the reduction of symptoms, changes in treatment, and clinical assessments, and personal recovery, which is defined by the individual's subjective sense of agency, purpose, and the ability to maintain relationships and daily activities.

When asked about non-therapeutic recovery models (such as peer support, Recovery Colleges, or other community-based frameworks), participants largely reported not using them in their practice. One mentioned everyday supports such as social connection, exercise, and hobbies. Another noted that non-therapeutic approaches are still rare in Serbia and often remain project-based rather than systematically included in mental health services. Overall, professionals recognized the value of such approaches but highlighted their limited presence within the formal system.

*“Clinical recovery can be measured as a reduction of symptoms, but personal recovery is about feeling ready to live a meaningful life in one's own way.”*

Citizens often associated recovery with overcoming difficulties such as trauma or addiction, where progress could sometimes be “proven” through visible changes. Several participants noted that recovery is ultimately a personal matter, only the individual themselves can truly know if they feel recovered. Others reflected on how the concept is shaped by medical discourse, which assumes a contrast between “ill” and “well,” and raised critical questions about who gets to define recovery and by what standards. Some linked recovery to social expectations, such as being functional, going to work, and participating in society, while others emphasized the possibility of a new beginning or a transformation into a different reality.

*“Recovery is a personal matter, only the individual themselves can truly know if they are recovered.”*

Decision makers described recovery in two main ways. One perspective emphasized recovery as the reduction or absence of symptoms, accompanied by the person’s ability to function independently in everyday life without frequent use of psychiatric services. Another view highlighted recovery as a process of adjustment, accepting new circumstances, facing them, and finding strength to continue life in changed conditions. Success in mental health care was linked to both subjective and objective indicators, such as a person’s awareness and acceptance of their situation, their efforts to cope and move forward, improvements in quality of life, daily functioning, and, when applicable, clinical measures.

*“Recovery means a process of adjustment, accepting the situation, facing it, and finding the strength to continue life in new conditions.”*

*“Success is when a person lives and functions in everyday life without relying on constant support from services or others.”*

Across groups, recovery was described as a process that extends beyond symptom reduction. Service users emphasized self-discovery, confidence, and mutual support in everyday life. Citizens tended to associate recovery with overcoming trauma or addiction, but some critically reflected on how recovery is defined and by whom. Professionals differentiated between clinical and personal recovery, but also pointed out that approaches beyond medical treatment remain scarce within current services. Decision makers reflected both clinical and personal perspectives, with some defining recovery in terms of independence from services and others as adaptation to new circumstances. These perspectives show that recovery is viewed as both personal and social, subjective and clinical, yet the lack of structured recovery-oriented practices within the system remains evident.

## 3.2 Current conditions (services, community, stigma and inclusivity)

When asked about available supports, service users mentioned only a small number of options. Formal services included psychiatric hospitals, day programs, general practitioners, and occasional private psychotherapy. Beyond this, two community resources were highlighted: Prostor, a community organization in Belgrade that provides psychosocial activities and support, and Duša, a self-organized peer group that meets within Prostor's space. These were valued not only for their activities but also for the sense of belonging and mutual support they foster. Family members, partners, and close friends were also seen as crucial sources of everyday encouragement and assistance.

Participants emphasized that barriers to access often outweighed the benefits of available services. Financial costs were repeatedly mentioned, particularly as a barrier to private therapy. Stigma and shame remained powerful obstacles, both in society and in interactions with professionals. Several participants described negative experiences of being turned away or dismissed, which deepened feelings of rejection. Practical challenges such as transport, time, health limitations, and lack of motivation also made it difficult to attend. Taken together, the accounts suggest that the range of services is very limited, leaving most people to rely primarily on psychiatric care, with very few accessible community-based supports.

*“In Serbia it is still a shame to ask for help.”*

Professionals stressed the lack of accessible community-based services, noting that support in Serbia is still dominated by institutional and medical approaches. They emphasized the need for services such as day centers, free self-help groups, crisis lines available 24/7, and programs that combine occupation, psychotherapy, and education. Special attention was given to the absence of systematic support for families. Some professionals said they do refer clients to emerging community services, but described these as fragmented and insufficient to meet the diverse needs of people in recovery. Another noted that these services remain underdeveloped largely due to limited state funding.

Barriers identified included financial costs, geographic distance, long waiting times, and a lack of information about what services exist. Above all, stigma was described as the most persistent obstacle, manifesting both externally (through critical attitudes and dismissive behaviors) and internally (as self-stigma, shame, and a sense of inadequacy). One professional emphasized that stigma is often expressed through delayed help-seeking, as many people avoid support out of fear of judgment. Stigma was also described as particularly strong for men in the Balkan context, where cultural expectations discourage emotional openness and often push people toward socially accepted but harmful coping mechanisms such as alcohol or gambling.

Non-clinical, community-based supports were seen as a potential game-changer in addressing these challenges. Professionals underlined that such approaches create safe spaces where people can share experiences without judgment, normalize conversations about mental health, and build

belonging and confidence. In their view, this not only reduces stigma but also strengthens the effectiveness of clinical care, helping people sustain long-term recovery.

*“We are still missing that community component which makes the medical approach meaningful and allows people to truly recover.”*

Citizens showed limited awareness of what community mental health services are, and some needed clarification of the term. They mainly associated support with services paid through employment or private arrangements, while very few were aware of free options. The few examples mentioned were *Prostor*, SOS helplines, feminist organizations, and associations supporting people with cognitive disabilities. Participants agreed that such services are not sufficiently promoted and that many people simply do not know where to turn for help.

They identified stigma as a major obstacle, noting that people often avoid seeking support for fear of being labeled or rejected. Participants stressed that using mental health services should be normalized. They suggested that better promotion of community services, collaboration with institutions, and public campaigns against stigma would encourage wider use. Several also noted that insufficient funding limits the availability of these services, and that both citizens and associations should demand more resources.

On a broader level, some reflected on how societal changes have affected inclusion. They contrasted today’s individualistic, neoliberal society with earlier forms of community life where people with mental health challenges had more recognized roles and purposes. They emphasized that building community and addressing structural inequalities could create conditions where mental health is understood not only as an individual issue but also as a collective responsibility.

*“People need to understand that it is normal to ask for help—just like going to the dentist.”*

Decision makers explained that their institutions are state-funded, which ensures continuity of treatment services but also keeps the focus on hospital- and clinic-based care. While some cooperation exists with other institutions and organizations, they acknowledged that current mental health programs only partially meet users’ needs. The system remains strongly oriented toward institutional solutions, while community-based services are underdeveloped, insufficiently recognized, and lack a clear legal framework. As a result, users struggle to access them or participate on equal terms with state institutions.

The main obstacles identified were stigma, lack of information, socio-economic difficulties, and practical challenges such as transportation, particularly in rural areas. Stigma was described as a central barrier, discouraging people from seeking help. Although some strategic documents and initiatives for improving community services exist, their implementation was described as slow and inconsistent. Overall, decision makers recognized significant gaps between institutional care and the community-based support that could complement it.

*“The system is still mainly focused on institutions, while community-based services remain underdeveloped and lack a clear legal framework.”*

Across all groups, participants highlighted the limited range of community-based mental health services in Serbia and the dominance of institutional care. Service users described relying mainly on psychiatric treatment, with only a few community initiatives available, and noted barriers such as finances, transport, and stigma. Citizens showed little awareness of free or community services, identifying *Prostor* and a few helplines as rare examples, and emphasized the need for better promotion and destigmatization. Professionals called for day centers, crisis lines, self-help groups, and family support programs, stressing that stigma, especially for men, remains the most persistent barrier. Decision makers acknowledged the same gaps, pointing to the lack of a legal framework and slow implementation of strategic initiatives. Taken together, these perspectives suggest that while there is recognition of the importance of community-based approaches, current services remain scarce, fragmented, and difficult to access, leaving most people dependent on institutional psychiatric care.

### 3.3 Recovery College Model

Most service users had not previously heard of the Recovery College model, with one participant mentioning they had come across it through *Prostor*'s online networks. After the concept was explained, participants strongly welcomed the idea. They emphasized that an active, educational approach would be “invaluable” compared to a passive reliance on medication. They saw the model as a way to build skills, share experiences, and learn from one another, highlighting the importance of spaces where people can exchange strategies for coping and support each other in their journeys. Some also underlined the value of developing the ability to help others, seeing this as an important part of recovery. Overall, service users viewed the Recovery College concept as innovative and full of potential for the future.

*“An active approach is much better than being passive and only taking medication.”*

Most professionals had not previously heard of the Recovery College model. One participant was familiar with it and described it as an educational approach that empowers people to take an active role in their recovery, combining professional expertise with the knowledge of people with lived experience. After the concept was explained, others recognized its potential as an innovative model that differs from traditional clinical services by focusing on learning, skills, and shared experience rather than treatment alone.

*“It is an approach to mental health based on education and empowerment, carried out together by professionals and people with lived experience.”*

None of the citizens had previously heard of the Recovery College model. After the concept was explained, they reacted positively, describing it as a promising direction. They saw value in an

approach that reduces the distance between people and services, focuses less on pathologizing individuals, and more on understanding the social conditions that shape mental health. For them, the idea of education and empowerment resonated as a way to shift the narrative away from “illness” and toward inclusion and collective wellbeing.

*“It sounds great, we need to move in this direction, to reduce the gap and make it less about pathology.”*

Decision makers had not previously heard of the Recovery College model. After the idea was explained, they found it interesting but raised immediate concerns about feasibility. In particular, they questioned how such a model would be funded and whether it could realistically receive government backing in the current system. While they acknowledged the potential value of the approach, their responses reflected uncertainty about its sustainability without clear financial and institutional support.

*“It sounds interesting, but it would be difficult to fund, and I am not sure the government would support it.”*

Across groups, the Recovery College model was largely unfamiliar, yet once explained it was met with strong interest. Service users welcomed the idea as an “invaluable” opportunity for active participation, peer support, and learning practical skills beyond medication. Citizens responded positively to the concept as a way to reduce pathologization and highlight the social dimensions of mental health. Professionals, though hearing about it for the first time, saw potential in an educational and empowering approach that could complement existing services. Decision makers were intrigued but cautious, raising concerns about funding and questioning whether government institutions would support such an initiative. Together, these perspectives show both enthusiasm for the model’s potential and recognition of the structural challenges to its implementation.

### 3.4 Coproduction, educational framework and integration of services

When discussing possible courses, participants expressed interest in a wide range of topics: relationship skills (how to approach and behave in relationships), literature, film, music, sports, psychodrama, prevention, and peer support. They highlighted the importance of courses where people can learn to provide and receive support, as well as preventive programs that help recognize early signs of difficulties. Several noted that younger people are often less engaged, while they themselves felt motivated to be active and contribute.

Opinions varied on how a Recovery College should be connected to existing systems. Some felt it should be closely linked with hospitals and include therapeutic elements such as occupational therapy or access to individual psychotherapy. Others preferred it to remain independent from

hospitals but still financially supported, without excessive institutional control. Participants emphasized that earlier access to such opportunities could have reduced their isolation and changed their recovery paths.

On co-production, service users understood it as a service created jointly by people with lived experience and professionals. They saw this positively, especially if it included collaboration between organizations such as *Prostor* and formal health institutions. They also welcomed the idea of peer-led activities, explaining that peers bring unique understanding and credibility. At the same time, they noted that such activities need to be well-prepared and adequately supported to be effective.

*“It feels good when a peer leads an activity, because they are in the same situation as us and truly understand.”*

Professionals emphasized that a Recovery College could support people by offering encouragement and building self-help skills, which in turn increase personal competence and reduce feelings of helplessness. They noted that the involvement of experts by experience would be particularly valuable in building trust, as this shared perspective helps motivate participants toward functional and meaningful lives. Education and training were described as important tools for fostering both motivation and resilience.

In discussing co-production, professionals consistently highlighted the importance of equal partnership between people with lived experience and trained experts. They saw co-production as the joint creation of program content, where personal insights, messages, and suggestions are integrated with professional knowledge and experience. This partnership was seen as a way to ensure that Recovery College content is relevant, grounded, and effective. They also stressed that reducing hierarchical divides between “professionals” and “service users” is crucial, and that people with lived experience should be recognized as equal collaborators rather than passive recipients of support.

*“Co-production means services are created not only by professionals, but together with people who have lived experience—both voices having equal value.”*

Citizens emphasized that including education and lived experience in the creation of services would bring significant value. They felt that personal experiences are often the most tangible and meaningful source of knowledge, helping others to better understand mental health and how to respond to people in distress. Several noted that professionals can sometimes lack empathy, while people with lived experience offer a unique perspective, similar to figures like Viktor Frankl who combined expertise with personal struggle. At the same time, they highlighted that participation must be inclusive and mindful of people’s socio-economic circumstances or current states of crisis, with safety measures in place to ensure accessibility.

When discussing potential course topics, citizens proposed stigma reduction, self-help, and better understanding of frequently used terms such as anxiety, depression, or jealousy, which are often misinterpreted in everyday language. They explained that learning to recognize and discuss such issues openly could have helped them earlier in life. Citizens also suggested consciousness-raising groups, inspired by feminist traditions, as safe spaces for dialogue that challenge norms and values, while teaching people to listen deeply to one another. In addition, they recommended courses on nonviolent communication and practical skills for managing emotions in the moment, not only reflecting on them afterwards. All agreed they would be interested in attending such programs.

*“Personal experiences are the most tangible and meaningful source of knowledge.”*

Decision makers believed that integrating a non-clinical model such as a Recovery College into the current system would be difficult, as there is no legal framework to support such initiatives. Without stronger state recognition and funding for independent organizations, they felt Recovery Colleges would remain primarily a civil society initiative rather than part of mainstream services.

At the same time, they acknowledged the potential value of Recovery Colleges in supporting reintegration into community life. They highlighted that such programs could strengthen individual capacities, encourage active participation, and reduce stigma by building on both knowledge and lived experience.

On co-production, decision makers recognized that it is currently very limited in Serbia, with decisions still dominated by the medical model. However, they saw room for change: through training, people with lived experience could be equipped to contribute equally alongside professionals. They stressed that genuine co-production would require systemic reforms, including new policies and institutional mechanisms that formally recognize experiential knowledge as equal to professional expertise.

*“There is no legal support for this model at the moment, without it, Recovery Colleges can only remain initiatives of the civil sector.”*

All groups agreed that education and shared experience could play a crucial role in recovery, but their perspectives reflected different priorities. Service users emphasized the value of diverse courses, from relationship skills to peer support and prevention, and stressed the importance of peer-led activities when properly supported. Citizens highlighted lived experience as the most meaningful source of knowledge, while also calling for inclusive participation that accounts for socio-economic barriers and ensures safe spaces. Professionals framed co-production as an equal partnership between experts by training and experts by experience, noting that such collaboration could build trust and motivation. Decision makers acknowledged the potential of Recovery Colleges for reintegration and stigma reduction but pointed to the absence of legal frameworks and systemic support, which currently limits co-production to isolated initiatives. Together, these perspectives suggest strong interest in educational and collaborative approaches, while underscoring the need for structural changes to embed them sustainably.

### 3.5 Implementation and sustainability

Service users described several elements they considered essential for feeling safe and supported in a Recovery College. They emphasized the importance of having committed volunteers and skilled, understanding professionals who can offer encouragement, trust, and warmth. A supportive environment was seen as one where participants feel understood, both by facilitators and by peers, and where mutual cooperation is fostered.

Practical conditions were also highlighted: access to food, a clean and well-equipped space with modern technology, and an atmosphere that is welcoming rather than clinical. Many stressed that the space should feel more like a community club than a hospital, somewhere people can drop in when they feel the need. At the same time, some suggested that participation should be somewhat structured, so that the space remains safe and purposeful without being entirely open to everyone at all times.

*“It should feel more like a club than a hospital, a place you can come whenever you feel the need.”*

Professionals identified several challenges for implementing and sustaining a Recovery College. The most pressing issues were financial and logistical: limited funding, lack of trained staff, and insufficient understanding of the value of non-medical approaches. They also pointed to the risk of instability among collaborators, noting that the program would need clear agreements and recognition of contributions to ensure continuity. Providing formal validation of work within such services was suggested as a way to motivate and retain collaborators.

For sustainability, professionals recommended using existing community spaces such as cultural centers, primary healthcare facilities, schools, and universities, which are already familiar and accessible to citizens. These “safe places” could help reduce stigma while making the program more visible and approachable. They also suggested promoting the model through social media, local events, and partnerships with associations and organizations already active in mental health and social inclusion. Ultimately, they stressed that long-term sustainability would depend on securing consistent state funding and reducing reliance on short-term project grants.

*“The main challenges are always financial and logistical, but also the lack of recognition for non-medical approaches.”*

Citizens emphasized that Recovery Colleges should not depend on unstable or charity-based funding, but instead be integrated into the public system and supported by the state. They argued that long-term sustainability requires institutionalization, ideally starting at the local level and eventually being incorporated into national strategies and action plans. Without this, they felt programs risk remaining temporary and fragile.

At the same time, they mentioned that alternative sources such as crowdfunding campaigns and donations could provide short-term support, noting that such initiatives have gained traction in Serbia. Some were critical of corporate funding practices, which they felt often prioritize image over real social impact. Citizens stressed that international cooperation and advocacy could also help put pressure on domestic institutions to adopt and support such models.

*“If these programs exist, they must include advocacy so the state funds them—otherwise they remain temporary and fragile.”*

Decision makers identified several key obstacles to implementing a Recovery College in Serbia. The greatest challenges were limited financial resources, lack of physical spaces, the absence of a clear legal framework, and institutional resistance within the system. They stressed that long-term sustainability would depend on government support, partnerships, and recognition of the model within official strategies.

As for indicators of success, some pointed to reduced demand for hospital-based services and lower costs of treatment, while others emphasized broader measures such as the number of participants, their reintegration into community life, reduction of stigma, and user satisfaction. They agreed that partnerships with state institutions, local communities, and civil society organizations would be essential.

Decision makers expressed openness to supporting a Recovery College, with possibilities ranging from public endorsement to logistical and partnership support. However, they noted that providing resources would require approval from higher authorities such as the Ministry of Health, highlighting the dependency of institutions on central decision-making.

*“The biggest obstacles are lack of funding, resources, and a legal framework—without government support, it is hard to imagine sustainability.”*

Across groups, participants identified sustainability as the greatest challenge for a Recovery College. Service users emphasized the importance of supportive staff, welcoming spaces, and accessible conditions that feel more like a community club than a hospital. Professionals highlighted financial and logistical barriers, lack of trained staff, and limited recognition of non-medical approaches, while also pointing to opportunities in using existing community spaces and partnerships. Citizens were clear that programs should not rely on unstable charity funding but be institutionalized and integrated into public systems, with advocacy and international cooperation seen as pathways toward change. Decision makers echoed concerns about funding, resources, and legal frameworks, while recognizing potential benefits such as reducing reliance on hospital care, lowering costs, and promoting reintegration and stigma reduction. Taken together, these perspectives show both strong support for the idea and a shared recognition that without systemic backing and stable funding, implementation will remain fragile.

## 4. Conclusion

This needs analysis highlights both the potential and the deep systemic challenges within Serbia's mental health landscape. Across all groups, recovery was described as a process that extends far beyond symptom reduction, one grounded in participation, meaning, and social connection. Yet the findings consistently point to a system still dominated by institutional care, a medicalized understanding of distress, and a lack of accessible community-based and recovery-oriented services. Although there is clear enthusiasm for educational and participatory models such as the Recovery College, implementation remains constrained by underfunding, fragmented coordination, and limited recognition of lived experience as an essential form of expertise.

The research was conducted during a period of political instability and widespread public protests. In such a context, it was not possible to include perspectives from higher-level policy representatives. Instead, institutional viewpoints were captured through decision makers working in psychiatric services, offering valuable insight into practice but not necessarily into broader policy direction.

This limitation reflects a broader systemic problem, one already identified in the *2024 Report on the Right to Mental Health in Serbia*, which concluded that the National Programme for Mental Health (2019–2026) remains only partially implemented, with weak coordination between sectors, absence of monitoring, and persistent underfunding. Five years into its duration, fewer than one-third of the planned measures have been realized, and there has been no visible progress in establishing community mental health centers or developing intersectoral protocols. The deinstitutionalization process has effectively stalled, while community services remain unevenly distributed and often dependent on short-term donor funding. These findings situate the current research within a context where innovation depends less on official policy and more on the initiative of local actors, NGOs, and professionals working at the margins of the system. Despite this stagnation, the qualitative data from this study reveal motivation, creativity, and readiness for change among service users, professionals, and community organizations. Their voices point to a shared vision of recovery as participation, learning, and mutual support, contrasting sharply with the existing structures of psychiatric care.

Looking ahead, the next phase of the Balkan Recovery College project can build on these findings by strengthening regional learning and cross-sector cooperation. The Serbian experience illustrates that meaningful transformation of the mental health system requires more than new models, it calls for political commitment, transparent governance, and the systematic inclusion of experiential knowledge as a foundation for both policy and practice.

## Appendix

### Appendix 1: Focus groups and interview questions

#### **A) Korisnici usluga (Fokus grupa)**

##### KONCEPTUALIZACIJA OPORAVKA

1. Šta za vas lično znači "oporavak"?
  - a. Šta vam pomaže da osjetite nadu, svrhu ili identitet izvan mentalnih zdravstvenih izazova s kojima se suočavate?
  - b. Da li ste imali osjećaj kontrole nad svojim procesom oporavka u prošlosti, ili sebe vidite kao pasivnog primaoca pomoći?
  - c. Šta bi podrazumijevalo "imati aktivnu ulogu u sopstvenom oporavku"?

##### TRENUTNO STANJE (POSTOJEĆE USLUGE, ZAJEDNICA, STIGMA I INKLUZIVNOST)

2. Sa kojim servisima mentalnog zdravlja ste upoznati i kako ocjenjujete njihovu efektivnost?
3. Koje prepreke vidite za svoje učešće (npr. stigma, transport, podrška, informacije...)?

##### RECOVERY COLLEGE MODEL

4. Da li ste čuli za Recovery College model rada u mentalnom zdravlju?
  - a. Dati pojašnjenje RC

##### KOPRODUKCIJA, OBRAZOVNI OKVIR I INTEGRACIJA USLUGA

5. Koja bi bila prednost pohađanja koledža koji se fokusira na obrazovanje i životne vještine, a ne na liječenje ili terapiju? Da li biste želeli da učestvujete u aktivnostima u okviru RC-a?
6. Koje vrste kurseva i tema bi vas najviše zanimalo? Kako biste željeli da se ovaj koledž poveže s uslugama mentalnog zdravlja koje već koristite, ili ste ih koristili u prošlosti?
7. Šta za vas znači da je neka usluga "koprodukovana"? A šta bi značilo da je "vođena od strane korisnika/vršnjaka"?

##### IMPLEMENTACIJA I ODRŽIVOST

8. Šta bi, po vašem mišljenju, bile najvažnije stvari koje bi koledž trebao imati kako biste se osjećali sigurno i podržano?

## **B)Stručnjaci za mentalno zdravlje (Intervju)**

### KONCEPTUALIZACIJA OPORAVKA

1. Šta za vas znači "oporavak"?
  - a. Kako biste opisali razliku između kliničkog i ličnog oporavka?
  - b. Koristite li ne-terapijske modele oporavka? Da li ste čuli za neke?

### TRENUTNO STANJE (POSTOJEĆE USLUGE, ZAJEDNICA, STIGMA I INKLUZIVNOST)

2. Koje usluge ne postoje, a smatrate da bi trebalo da postoje? Da li vaše klijente upućujete na usluge mentalnog zdravlja u zajednici?
  - a. Gledano dugoročno, u kojoj mjeri postojeći servisi podržavaju proces oporavka stručnjaka po iskustvu?
3. Koje prepreke vidite za učesće osoba u servisima mentalnog zdravlja u zajednici? Kako se stigma manifestuje u vašoj zajednici i kakvi su učinci na ljude s kojima radite?
4. Koju ulogu bi, po vašem mišljenju, neklinička usluga u zajednici mogla imati u smanjenju stigme i u povećanju uključenosti?

### RECOVERY COLLEGE MODEL

5. Da li ste čuli za Recovery College model rada u mentalnom zdravlju?
  - a. Dati pojašnjenje RC

### KOPRODUKCIJA, OBRAZOVNI OKVIR I INTEGRACIJA USLUGA

6. Na koji način bi ne-klinički, edukativni pristup poput RC-a mogao koristiti osobama sa poteškoćama MZ u njihovom procesu oporavka? Da li biste želeli učestvovati u aktivnostima RC? Kakvu ulogu podrška kroz edukaciju i trening za samopomoć mogu imati u oporavku?
7. Kako vi razumijete koprodukciju u uslugama mentalnog zdravlja? Šta treba da postoji ili da se desi kako bi postojala veća saradnja između stručnjaka i ljudi s ličnim iskustvom? Kako bi stručnjaci mogli doprineti kokreiranju sadržaja RC-a?

### IMPLEMENTACIJA I ODRŽIVOST

8. Koji su najveći percipirani rizici ili izazovi u implementaciji nove usluge poput ove (recovery college)? Kako osigurati dugoročnu održivost ovakvih programa? Koja bi se postojeća sredstva ili prostori u zajednici mogli iskoristiti za podršku njegovom radu?

## **C)      Građani (Fokus grupa)**

### **KONCEPTUALIZACIJA OPORAVKA**

1. Kada čujete riječ "oporavak" u kontekstu mentalnog zdravlja, šta vam prvo pada na pamet?

### **TREKUTNO STANJE (POSTOJEĆE USLUGE, ZAJEDNICA, STIGMA I INKLUZIVNOST)**

2. Da li znate za usluge mentalnog zdravlja u zajednici? Da li ste vi ili neko vama blizak koristili te usluge? Šta mislite da nedostaje?
3. Kako bi se zajednica mogla više uključiti u podršku mentalnom zdravlju?

### **RECOVERY COLLEGE MODEL**

4. Da li ste čuli za Recovery College model rada u mentalnom zdravlju?
  - a. Dati pojašnjenje RC

### **KOPRODUKCIJA, OBRAZOVNI OKVIR I INTEGRACIJA USLUGA**

5. Vjerujete li da obrazovanje može biti koristan alat za oporavak mentalnog zdravlja?
6. Koje teme bi RC trebao pokriti? Da li biste lično učestvovali u takvim edukacijama ili radionicama? Zašto da/ne?
7. Smatrate li da bi se ljudi s ličnim iskustvom mentalnih poteškoća trebali uključiti u osmišljavanje i pružanje usluga? Zašto da/ne? Šta je prepreka?

### **IMPLEMENTACIJA I ODRŽIVOST**

8. Koja bi se postojeća sredstva ili prostori u zajednici mogli iskoristiti za podršku njegovom radu? Kako osigurati dugoročnu održivost ovakvih programa?

## **D) Donosioci odluka (Intervju)**

### **KONCEPTUALIZACIJA OPORAVKA**

1. U okviru onoga što je vama poznato, vaše pozicije u ustanovi u kojoj radite kako se definiše oporavak?
2. Kako se definiše uspjeh u skrbi o mentalnom zdravlju? Postoje li neki pokazatelji (mjerjenja, praćenja, drugi izvori podataka)?

### **TREKUTNO STANJE (POSTOJEĆE USLUGE, ZAJEDNICA, STIGMA I INKLUZIVNOST)**

3. Kako je vaša institucija povezana sa uslugama koje postoje (finansiranje, pružanje usluga, suradnja...)?
4. Da li postojeći programi mentalnog zdravlja zadovoljavaju potrebe korisnika? Koje nedostatke vidite u postojećem sistemu podrške?
5. Koje su prepreke za učešće građana u servisima za mentalno zdravlje (stigma, informiranost, socio-ekonomске teškoće, prevoz...)?
6. Da li postoje neki dokumenti ili inicijative (strategije, planovi, radne grupe...) za unaprijeđenje postojećih servisa?

### **RECOVERY COLLEGE MODEL**

7. Da li ste čuli za Recovery College model rada u mentalnom zdravlju?
  - a. Dati pojašnjenje RC

### **KOPRODUKCIJA, OBRAZOVNI OKVIR I INTEGRACIJA USLUGA**

8. Kako bi se neklinički model poput Recovery College-a uklopio u postojeći sistem pružanja usluga mentalnog zdravlja?
  - a. Da li bi mogao podržati reintegraciju ljudi s mentalnim zdravstvenim izazovima u život zajednice?
9. Kako gledate na koncept koprodukcije u trenutnim uslugama? Da li je prisutan i (ako nije) da li je moguć?
10. Koje bi politike ili okviri bili potrebni da se korisnicima usluga omogući da budu "jednaki partneri" u osmišljavanju i pružanju podrške za mentalno zdravlje?

### **IMPLEMENTACIJA I ODRŽIVOST**

11. Koje prepreke ili izazove predviđate u implementaciji ovog modela? Šta je potrebno kako bi imao finansijsku podršku i koji bi bili ključni pokazatelji uspeha?
12. Koja partnerstva bi bila najvažnija za uspješno i održivo funkcionisanje? Koje ciljeve bi RC trebalo da ima da bi dobio podršku?
13. Da li bi vaša institucija podržala rad Recovery college i kako bi ta podrška izgledala (deklarativno, novčano, logistički, partnerski...)?



**Balkan Recovery College**

BALKAN HEARING VOICES NETWORK

# **NEEDS ANALYSIS COUNTRY REPORT**

**Slovenia**



Co-funded by  
the European Union

Erasmus+ project, 2025

## Contents

1. Introduction .....	3
2. Methodology .....	4
2.1 Participants .....	4
2.2 Instruments .....	4
2.3 Procedure.....	4
3. Results .....	5
3.1 The conceptualization of recovery .....	5
3.2 Current conditions (services, community, stigma and inclusivity) .....	7
3.3 Recovery College Model .....	9
3.4 Coproduction, educational framework and integration of services.....	9
3.5 Implementation and sustainability .....	12
4. Conclusion .....	14
Appendix .....	16
Appendix 1: Focus groups and interview questions .....	16

# 1. Introduction

This research was conducted as part of the Balkan Recovery College Erasmus+ project. It was done in four partner countries by local project teams in Bosnia and Herzegovina, Croatia, Slovenia and Serbia. In this report, we will focus specifically on Slovenia.

The purpose of this research is to map the local needs in each country through focus groups and interviews, regarding the organizational structure and main focus of the Recovery College model. It is the second step in developing Recovery College model for the four project countries. First step was desk research, a thorough literature review which provided a comprehensive overview of the principles, evidence base, and implementation challenges of Recovery Colleges. Desk research report also gave us direction for what to focus on in needs mapping.

Through co-production among project country teams, with the supervision of Camden & Islington NHS Foundation Trust, we derived five areas of research interest based on the previous desk research report. These are: (1) Conceptualization of recovery, (2) Current conditions (services, community, stigma and inclusivity), (3) Recovery college model, (4) Coproduction, educational framework and integration of services, and (5) Implementation and sustainability.

Each country's local project team provided a list of suggested stakeholders for focus groups and interviews, which was reviewed and approved by the whole project team. After that, we developed guidelines and questions for conducting the focus groups and interviews, all in accordance with the principles of co-production.

Results will be presented by theme and by participant group. In conclusion we will provide recommendations for further Balkan Recovery College model development.

## *Disclaimer*

*This document is committed to using inclusive, respectful, and sensitive language that upholds the dignity of all individuals. However, certain terms used in the text may not align with current standards of sensitive or person-first language. The views and terms expressed in this report do not necessarily reflect the attitudes or values of the authors, but rather those of the research participants.*

## 2. Methodology

### 2.1 Participants

In the research, we had four target groups of participants: service users, mental health professionals, citizens, and decision makers. Participants were recruited for participation through social media advertising and using the snowball technique.

A total of 3 focus groups were conducted (with 2 involving service users and 1 involving citizens), along with 3 interviews.

A total of 20 participants took part in the research, specifically: 10 service users, 7 citizens, 3 mental health professionals, and 0 decision makers.

### 2.2 Instruments

We developed guidelines and questions for conducting the focus groups and interviews, adhering to the principles of co-production (Appendix 1). Questions were adapted for each participant group to specifically reflect their experiences. For example, on the topic of recovery, service users were asked about their personal experience of recovery, while mental health professionals were asked about differences between personal and clinical recovery concepts.

Same questions were used in all project countries.

### 2.3 Procedure

The focus groups and interviews were conducted between June and September. On average, the focus groups lasted 1 hour and 30 minutes, and the interviews lasted up to 1 hour. We obtained informed consent from all participants to conduct the interviews, record them, and process the data. All interviews and focus groups were audio recorded and subsequently transcribed. These transcripts were then used for the analysis and the results presented below.

## 3. Results

Results are presented as five themes that were our focus. For each theme, we presented findings from each participant group, as well as conclusions on differences and similarities in their answers.

### 3.1 The conceptualization of recovery

**Service users** defined recovery as a process or journey toward well-being and the gradual acceptance of increasing responsibility for one's life, a process of working through emotions, developing self-compassion, recognizing the need for help when necessary, achieving greater activity and independence, and strengthening the capacity to participate in various relationships and social activities. As one focus group participant explained: *"Yes, I would say psychological, physical, bodily, and spiritual health... That you know how to cope with challenges, difficulties, whatever it may be. So that you can handle everything that comes your way — if not alone, then with support, whether from supportive friends, a support group, or whatever. That you know how to manage life situations."* The vast majority of interviewed users (9 out of 10) agreed that recovery is possible even in the presence of symptoms (or that symptoms are part of recovery) or despite relapses, with some emphasizing the importance of knowing a set of tools or strategies that individuals can draw upon to manage difficulties more effectively. One participant, however, stressed that recovery in the presence of symptoms was not possible, as symptoms prevented her from maintaining contact with everyday life. Users identified several factors that hinder recovery, including external factors (various life circumstances), relational factors (family situations, lack of understanding and support, stigma and the consequent absence of space to share distress, lack of friendships or social networks, or unsuitable company), systemic shortcomings (non-integrated services that fail to meet the complex needs of users, pharmacological treatment or inappropriate therapy), and internal factors (loss of motivation, limiting beliefs, "triggers"). Conversely, factors that helped them maintain a sense of hope or identity despite mental health difficulties included leisure activities (walking and other activities in nature, reading, enjoying good and healthy food), work, conversations with close others or mental health professionals, stories of others who had recovered, friendship, and faith. Service users' experiences of control over their own recovery processes varied considerably. Three reported a continuous sense of agency (one of whom emphasized in particular the supportive role of her mother and her psychotherapist), one reported complete passivity, five experienced both passivity and activity at different times, and one did not take a position on the question.

**Mental health professionals** conceptualize recovery as a process of developing tools for coping with mental health challenges and difficulties in mental health, establishing physical and psychological well-being, fostering positive self-acceptance, and ensuring engagement and participation in social life. All interviewees view recovery as broader than clinical recovery, which they primarily associate with the reduction or absence of symptoms. Personal recovery, by contrast, is understood as acknowledging the perspective of the person with lived experience of mental distress, emphasizing their active role in the process, and supporting the development of self-help skills. As stated by one of the interviewees: *"I perceive recovery as a process of*

*personal and social development that follows a life crisis, in which the individual becomes empowered to move from the passive role of the victim or patient (i.e., the object of treatment) into the role of an active and more autonomous subject of their own life, guided by optimistic visions and my positive self-acceptance.*» In their professional practice, all three interviewees reported employing non-therapeutic approaches to recovery, such as organizing support groups, conducting informal conversations, organizing sports activities for service users, shared meal preparation, practicing advocacy, and delivering psychoeducational workshops.

**Citizens** associated recovery with concepts such as rest, vacation, leisure, relaxation, nature, the absence of obligations, and health. Importantly, most did not equate recovery with the mere absence of symptoms, but rather as a prolonged and gradual effort directed towards achieving a satisfactory standard of living, the ability to function socially (e.g., fulfilling obligations, communicating), as well as the acceptance of persisting difficulties. Two participants further emphasized the importance of the nature of symptomatology, noting the unrealistic expectation of a situation in which a person would have no symptoms at all, particularly when mental health problems are rooted more in biological than environmental factors, or in cases of more severe and chronic conditions. For one focus group participant, recovery was linked to a reorganization of life following a crisis and to the attainment stability, understood as the ability to function normally in society without extreme mood fluctuations: *“Some things, especially in mental health, are not like the flu, which you treat once and it disappears, but can always linger somewhere in the background.”*

**Conclusion.** Overall, participants consistently defined recovery as a process and understood it more broadly than the clinical definition, which reduces recovery to the absence of symptoms. With the exception of one service user, all agreed that recovery is possible even in the presence of symptoms. Participants consistently linked recovery with achieving a certain level of life satisfaction, developing self-compassion, and the ability to participate in social life. However, service users and mental health professionals placed greater emphasis on active involvement in one’s own recovery, the development of coping strategies, and the assumption of responsibility for one’s life, whereas citizens stressed more strongly the individual’s capacity to function in accordance with the demands of society. Notably, although citizens generally agreed that recovery is possible alongside persisting symptoms, their accounts contained certain contradictions: recovery was simultaneously described as compatible with symptom presence yet equated with stability, which they defined as the absence of extreme mood fluctuations—symptoms that are themselves characteristic of mental health difficulties. Finally, only mental health professionals explicitly underscored the importance of incorporating the perspective of the person with lived experience of mental distress into understandings of recovery.

## 3.2 Current conditions (services, community, stigma and inclusivity)

**Service users** identified a range of mental health services, including psychotherapy, self-help groups (such as Alcoholics Anonymous), peer support groups, detoxification centers for substance use, psychiatric and psychological treatment, general practitioners, programs offered by employment agencies, alternative practices (energy healing), and services provided by non-governmental organizations. Psychotherapy and self-help or support groups were evaluated positively, while detoxification centers were viewed negatively. Psychiatric treatment was recognized by some users as an important form of support at certain times, though not a sufficient one. With regard to possible improvements, focus group participants proposed the establishment of spaces enabling treatment without medication and the provision of accommodation support for individuals in acute crisis, the creation of jobs for people with lived experience of mental health difficulties alongside greater recognition of such professions, the formalization of the occupational profile of peer support workers, easier access to psychotherapy, and stronger collaboration between psychotherapy and psychiatry. Reported barriers to participation included transportation difficulties, lack of time due to societal pressures related to productivity and employment, financial constraints, numbness and lack of motivation as side effects of psychiatric medication, anxiety linked to meeting strangers, and oversaturation with particular forms of support (for instance, group therapy that no longer posed sufficient challenges for the individual). As one participant explained: *“The main problems are transport and finances. I do not attend [organization name] or [organization name], where there are too many people on medication. I am not interested in organizations where people are not motivated to do anything for themselves. When I am on medication, I also feel more numb myself.”*

**Mental health professionals** also reflected on the broader system of care in Slovenia, noting that the dominant model for addressing mental health difficulties remains the psychopharmaceutical approach (medication-based therapy). As one interviewee emphasized: *“This model, which holds an almost complete dominance in this field, does not recognize the value of alternative approaches, particularly psychotherapeutic ones, and largely denies or even ‘suppresses’ them (regarding them as harmful).”* Interviewees agreed that there is a lack of other forms of support for people experiencing mental distress, such as a systemically regulated and remunerated model of peer support work, individualized free assistance tailored to the needs of service users, and a greater number of self-help groups. Among the existing services that provide longer-term support for recovery, they highlighted programs offered by certain non-governmental organizations. However, these organizations face financial constraints (limited funding and the requirement to adapt programs to the expectations of funders) as well as spatial limitations, and their services are often conditional on prior compliance with requirements derived from the medical understanding of mental illness. One interviewee working within an NGO in the mental health field also stressed the difference between the abundance of services and their actual effectiveness: *“Yes, but one thing is the form and the sheer number of services, and another is the content and effectiveness of those services. We may have a whole range of activities, where we can declaratively claim that we have everything and that our users could hardly be more included, but if these activities are empty, if our users are not yet strong enough*

*to participate actively in them, then it is not sufficient.”* With regard to obstacles to building collaborative relationships with users, interviewees pointed to difficulties in stepping out of the role of the expert as the one who teaches, the challenge of relinquishing power, and the monopolistic position of the medical model in psychiatry and, more broadly, in public understanding. Collaboration is further hindered by the dependence of service providers on funders, as well as the routinized nature of certain programs (e.g., those operating for decades), which makes it difficult for professionals to identify potential alternatives. Active and equal participation of users is also constrained by self-stigmatization stemming from external stigma, feelings of shame about one’s difficulties, and excessive medicalization, which tends to render individuals passive. As one interviewee concluded regarding the importance of non-clinical community services: *“Non-clinical services in the community should in themselves embody (that is, develop) modes of inclusion and contribute to the normalization of different forms of mental distress.”*

**Citizens** mentioned a variety of community-based mental health services, including youth centers, self-help and support groups, day centers, humanitarian programs, community mental health centers, programs of the National Institute of Public Health, as well as alternative practices (e.g., fortune-telling) and the use of Chat GPT, toward which they expressed critical views. None of the participants had personally attended any of the listed services, although some had directed acquaintances or relatives to them. One participant reported having previously accessed psychological support within the public health system and psychotherapeutic assistance, the latter being particularly positively evaluated. Some participants had also encountered content related to mental health through workplace initiatives, particularly in educational institutions. Focus group participants emphasized that the community should play a stronger preventive role in providing mental health support, particularly through awareness-raising and encouraging public discussion of mental health topics (including the destigmatization of mental health, especially among older generations), fostering an accepting environment beginning in primary education, and offering preventive workshops on mental health. They also highlighted the importance of destigmatization, with one participant noting: *“Less judgment. It seems to me that some people keep looking back at a person and cannot recognize them as they once were. Acceptance, regardless of who the person is now or who they will be in the future.”* At the same time, another participant stressed the need for stricter approaches, including earlier detection, faster responsiveness of relevant services, a lower threshold of tolerance toward certain deviant behaviors or states, and longer-term institutional care.

**Conclusion.** Both service users and citizens identified a wide range of different forms of support in the field of mental health, with both groups also positively evaluating psychotherapeutic assistance. Service users and professionals alike emphasized the need to complement the psychopharmaceutical or medical model with alternative forms of support and to establish a systemically regulated and remunerated model of peer support work. Citizens and service users also mentioned alternative practices (such as energy healing and fortune-telling). While citizens expressed critical views toward these, service users tended to adopt a more positive stance. Within the citizens’ group, one participant highlighted the need for faster intervention and a lower threshold for admission to institutional psychiatric care. It is important

to note that this participant was a relative of a person with long-term experience of mental health difficulties. Whereas professionals pointed to stigma as well as financial and organizational limitations of programs as barriers to user participation, service users primarily emphasized logistical obstacles, such as transportation difficulties and lack of time. Both groups identified numbness and lack of motivation resulting from psychiatric medication as a further barrier.

### 3.3 Recovery College Model

None of the participants in the focus groups with service users and citizens had previously heard of the Recovery College model. Among the mental health professionals, only one of the three interviewees was familiar with the model, having encountered the concept while reading literature in the field. Overall, the Recovery College model is not well known in the Slovenian context.

### 3.4 Coproduction, educational framework and integration of services

Most **service users** expressed an interest in participating in Recovery College activities, with some wishing to take on a more active role and others preferring to engage occasionally or as needed. Only one participant indicated that she would not currently wish to attend such a program. With regard to the potential benefits of participation in an education- and life-skills-oriented program, focus group participants emphasized its holistic character and the integration of different forms of knowledge (both professional and experiential), greater effectiveness in addressing various difficulties (e.g., how to respond in an acute crisis), improved flow of information, the broadening of definitions and pathways of recovery, opportunities for knowledge- and experience-sharing, and the strengthening of social networks. Suggested courses and topics included assertiveness and boundary-setting training, the creation of space for alternative perspectives (e.g., paranormal phenomena), neurolinguistic programming (NLP), crisis management, communication with institutions (such as occupational medicine), and support in reducing or discontinuing psychiatric medication. Participants envisioned the coproduction of knowledge as an encounter of diverse perspectives that can be aligned and complemented, stressing in particular the importance of avoiding situations where one individual (whether a professional by training or by experience) monopolizes the space with their perspective. As one participant explained: *“To see, in one place, all the different spectrums of recovery, all the different things. Because one thing works for one person, another thing for another... Not all recoveries are the same for everyone; the idea is that in the end you would learn about different paths. We had to spend many years exploring different options and recovery pathways in order to have a realistic picture. But there you could get all of this in one place.”* In relation to the problem of monopolizing knowledge or viewpoints, one participant further stressed the need for Recovery College participants to acquire skills in facilitating support groups.

All interviewed **mental health professionals** expressed an interest in participating in Recovery College activities. They believed that an educational approach such as the Recovery College could help individuals regain strength and motivation for active engagement and mutual connection, foster trust in their pre-existing capacities, and support the development of self-advocacy competencies. As one interviewee explained: *“Yes, great, I think this idea sounds great. And to me it seems essential. Not only interesting, but essential. I believe that the closed nature of education in general is by far the greatest problem of the school system. People want knowledge, people want skills, we want, through this knowledge and these skills, to be included somewhere; sometimes we want this simply because the world is organized in such a way that a person must work, must contribute. But nevertheless, regardless of why a person wants something, I believe that all people want to be included and to be part of something. And the closed nature of the educational system—not only schooling, but education in general—very often distances people from this rather than bringing them closer. I think this could really help to change that.”* Another professional suggested that education as a formal practice contains within it the potential for co-creation and the building of social networks; however, when reduced to the mere transfer of pre-prepared knowledge into people’s heads, its role can become the very opposite of supportive. They further emphasized the importance of developing institutional recognition of collaborative work and securing the financial resources needed to sustain it. Interviewees understood coproduction as working together, listening to and truly hearing the voices of others. They associated it with the active involvement of service users in the design, delivery, and evaluation of services, stressing that it is crucial for users to perceive these services as meaningful. With regard to the conditions necessary for collaboration between professionals by training and professionals by experience, one interviewee noted: *“For collaboration between professionals by training and by experience to be possible, there must be a truly equal relationship in which members actively listen to each other and respect their diverse knowledge.”* Professionals primarily saw their contribution to content creation as the development of relationships grounded in genuine interest and a willingness to listen to the wishes and needs of service users, as well as supporting the creation of content that users themselves recognize as meaningful and useful. Within the Recovery College, they envisioned contributing by linking users’ experiential knowledge with professional expertise and with insights into what had been helpful for others in similar situations, while at the same time enhancing their own knowledge. They also regarded their role in socially legitimizing this type of work and ensuring its continuity as significant.

**Citizens** identified the advantages of the Recovery College in its potential to provide more integrated services by connecting various fragmented forms of support, in strengthening the link between theory and practice, and in establishing a learning environment that could serve as a source of motivation for individuals. They also highlighted as a benefit the possibility of offering a very broad range of diverse content and reaching a wide and heterogeneous population. Suggested topics for Recovery College activities included issues related to everyday life (such as developing work habits, adopting a healthy lifestyle, and communication skills) as well as content designed for relatives (e.g., supporting family members living with a person experiencing mental health difficulties). At the same time, participants expressed several concerns regarding possible challenges. These included the need for carefully considered

implementation, the risk of discrepancies between idealistic theory and actual life situations, and the concern that people with mental health difficulties who participate in the program would need to have a relatively high degree of control over their symptoms. One participant, in particular, elaborated extensively on these issues, stating: *“It seems to me that this is a program that was designed with this very purpose in mind... It probably requires some infrastructure; it is not just something we can decide to do and that’s it. We have been in this period of deinstitutionalization for some time, then there is positive behavioral support, and one does not know where to begin or where to end. On the one hand, you ask yourself what an institution even is. Children are closed in. I mean, yes, it sounds harsh, but the more you sugarcoat things, the less clear it becomes what you are actually doing. It seems to me that everyone would like to live in some kind of fairy tale...”* He continued: *“It is difficult. This program works on the assumption that the people there are, for the most part, very stable.”* Later, he added: *“I think that any such initiative, which is well-intentioned and aims to achieve something good, always begins very optimistically. The problem comes when it encounters reality. Then this optimism becomes increasingly reduced. It would be nice if everyone could remain positive and optimistic all the time... But many people under your supervision in such programs are such that you soon have had enough. It sounds bad, but some people are simply very demanding, generally ungrateful... You can try as hard as you want, but you still end up having had enough.”* Citizens thus acknowledged the added value of co-created services, yet some expressed skepticism regarding the realistic possibilities of establishing such a model. In their view, the main challenges lie in how to cultivate motivation among people to create and participate in such a service, particularly if it were to operate on a voluntary basis.

**Conclusion.** All participants emphasized and positively evaluated the broadening of knowledge and perspectives that the Recovery College model could bring to the field of mental health. Professionals particularly highlighted the importance of establishing an open learning environment with the potential to expand participants’ opportunities, whereas service users stressed its potential to provide more effective ways of addressing difficulties. Among the topics that the Recovery College should include, both service users and citizens mentioned areas related to managing everyday life. Although the model was presented during the focus group as a space open to everyone, citizens tended to reflect on potential content primarily from the perspective of people with mental health difficulties, which may indicate a certain degree of distance from the idea as it was introduced. While professionals pointed to the risk that the Recovery College could be reduced to a one-way transfer of knowledge rather than the co-creation of a learning space, citizens identified the main challenge as the ability of people with mental health difficulties to participate effectively and the issue of participant motivation. The participant who raised concerns about the discrepancy between what he considered an idealistic vision and real-life circumstances was not a mental health professional, but he did have experience working in an institutional context.

### 3.5 Implementation and sustainability

**Service users** considered the most important condition for participating in the Recovery College to be the creation of a safe and supportive environment. They emphasized the need for an easily accessible and secure space (e.g., smaller groups, compassionate delivery of lectures, interactivity, clear rules, and skills for conflict resolution). Relationships should be based on openness, acceptance, and understanding. Equally important was financial accessibility (affordable or free of charge) and content accessibility (the use of simple, comprehensible language in the delivery of educational content). As one participant explained: *“Acceptance, that you can see that everyone there is accepting. That is it, sometimes it needs to be even more obvious. Everyone, when they step in, has to make an effort to show clearly that they accept everyone, that they are obviously that kind of person.”*

**Mental health professionals** saw the greatest challenge in the uncertainty accompanying the introduction of a new model of work and the transformation of established professional paradigms. The most difficult step, in their view, was overcoming the belief that such an initiative is impossible. As one interviewee remarked: *“The biggest problem with good practice is that everyone knows it is good practice, but no one turns it into practice.”* Other risks identified by professionals included the possibility that the Recovery College might, over time, become an extension of the existing medical model, the persistence of professional monopolies and the difficulty of relinquishing expert positions within mental health care, as well as issues of funding—both in terms of how much financial support would be allocated and the potential limitations of the program’s scope if adequate resources could not be secured. One professional stressed the importance of connecting with existing services: *“It is necessary to design a solid action plan for the development and implementation of such services, to actively involve users, professionals, and decision-makers throughout, and to build connections with existing community services that can provide premises, human resources, and similar support.”*

**Citizens** stressed that the implementation of the Recovery College model should take into account the specific features of the society in which it would be established. Key steps would include securing funding, finding suitable premises, and ensuring adequate staffing. As an important factor in ensuring the sustainability of such a program, they highlighted paid employment: *“If a volunteer does this work for a long time, they get exhausted, and it is good if they receive something in return. Sometimes personal satisfaction is not enough; they also need something more.”*

**Conclusion.** Across groups, participants recognized the potential of the Recovery College but highlighted different conditions and risks. Mental health professionals emphasized the need to take the first step in shifting entrenched paradigms, along with challenges of financing and the risk of the model being reshaped in line with the medical framework. Citizens similarly stressed the issue of funding, while also pointing to the importance of adapting implementation to cultural and societal specificities. Notably, citizens highlighted paid employment as a key factor for sustainability—an issue also raised by both professionals and service users in relation to expanding existing forms of support in mental health care. Service users, in turn, placed

particular emphasis on the spatial and organizational conditions needed to feel safe and supported, and above all the creation of an environment in which acceptance is made visible.

## 4. Conclusion

Participants in the study understood recovery more broadly than the clinical conception, and did not associate it necessarily with the absence of symptoms. They linked recovery to achieving satisfaction with one's life, developing self-compassion, and the ability to participate actively in society. Service users and professionals placed greater emphasis on the individual's active role in the recovery process and on the development of strategies or tools for managing difficulties, whereas citizens focused more on the capacity to function in line with societal demands.

With regard to mental health services, both service users and professionals highlighted the need to expand the range of available options, including the establishment of a systemically regulated and remunerated model of peer support work. Barriers to participation and co-creation in support services differed across groups: professionals pointed to stigma as well as financial and organizational limitations of programs, while service users emphasized logistical challenges, such as transportation and lack of time. Both groups also noted the numbing effects of psychiatric medication as an obstacle.

All participants saw in the Recovery College model an opportunity to broaden knowledge and perspectives. Professionals stressed the importance of creating an open learning environment, while service users emphasized the potential for more effective problem-solving. Among the three groups, citizens expressed the greatest degree of skepticism, particularly concerning the motivation of people with lived experience of mental health difficulties and their capacity to participate in such a program.

Regarding the challenges of implementation, professionals pointed to the need for a paradigm shift in mental health (stepping out of positions of power and transferring power to people with lived experience), the issue of funding, and the risk of reverting to practices aligned with the medical model. Across all three groups, participants emphasized the importance of paid employment for people with lived experience of mental health difficulties.

The limitations of this research stem from the chosen methodology. The participant sample we used cannot provide a complete overview of the entire system's status within each country, nor was that our goal. A limitation of the study is that the sample did not include the perspectives of decision-makers. It should also be noted that the professionals interviewed were active within non-governmental organizations in the field of mental health. It is possible that if the interviews had included professionals employed within the health care system, the results might have been different. Furthermore, it is important to highlight that in 2025, peer support in the field of mental health is being formally established for the first time in the Republic of Slovenia. Until now, such initiatives existed only within certain non-governmental organizations, where the prevailing model remained one in which services were led by professionals, while people with lived experience of mental health difficulties did not hold a decisive role in their planning, delivery, or implementation.

Although qualitative methods lack the generalizability of quantitative approaches, they crucially offer insight into the "how" and "why."

We chose this qualitative approach specifically because of its strengths: to gain a deeper and richer understanding of the situation, drawn directly from the personal experiences of people living and working in the contexts where the Recovery College model will be implemented.

### **Recommendations for further development of the Recovery College model**

Based on the findings of this report, further efforts in developing the Recovery College model should be directed toward establishing a program grounded in lived experience, oriented toward achieving a subjectively defined level of life satisfaction, and enhancing opportunities for social participation. Particular attention should be devoted to maintaining the plurality of approaches and content, as well as encouraging contributions from all participants. Given that different participants can be expected to respond differently to the content of the Recovery College, the creation of an accepting environment will be one of its key orientations. Ensuring accessibility will require attention to logistical barriers (such as transportation and scheduling) and organizational adaptations (smaller groups, compassionate delivery, interactivity, clear rules, and conflict resolution skills).

There is also an emerging need to explore possibilities for establishing a structure that would allow participants to engage in paid peer support work in some form (for example, through tutoring), and to strengthen connections with existing services and non-governmental organizations active in the field of mental health. Efforts should be oriented toward developing strategies to motivate and support participants, with particular emphasis on finding ways to make the program accessible to the broader public, not only to people with lived experience of mental health difficulties or professionals employed in non-governmental organizations. By fostering connections among professionals, service users, and the wider community, the risk of the Recovery College becoming established merely as another curative mental health service can be avoided.

Finally, in ensuring sustainability and funding, it will be crucial to identify appropriate sources of financing that allow the Recovery College to maintain a sufficient degree of autonomy and sustainability. These are all issues that will be further explored during our field visit to London, UK, in December.

## Appendix

### Appendix 1: Focus groups and interview questions

#### **A) Korisnici usluga (Fokus grupa)**

##### KONCEPTUALIZACIJA OPORAVKA

1. Šta za vas lično znači "oporavak"?
  - a. Šta vam pomaže da osjetite nadu, svrhu ili identitet izvan mentalnih zdravstvenih izazova s kojima se suočavate?
  - b. Da li ste imali osjećaj kontrole nad svojim procesom oporavka u prošlosti, ili sebe vidite kao pasivnog primaoca pomoći?
  - c. Šta bi podrazumijevalo "imati aktivnu ulogu u sopstvenom oporavku"?

##### TRENUTNO STANJE (POSTOJEĆE USLUGE, ZAJEDNICA, STIGMA I INKLUZIVNOST)

2. Sa kojim servisima mentalnog zdravlja ste upoznati i kako ocjenjujete njihovu efektivnost?
3. Koje prepreke vidite za svoje učešće (npr. stigma, transport, podrška, informacije...)?

##### RECOVERY COLLEGE MODEL

4. Da li ste čuli za Recovery College model rada u mentalnom zdravlju?
  - a. Dati pojašnjenje RC

##### KOPRODUKCIJA, OBRAZOVNI OKVIR I INTEGRACIJA USLUGA

5. Koja bi bila prednost pohađanja koledža koji se fokusira na obrazovanje i životne vještine, a ne na liječenje ili terapiju? Da li biste želeli da učestvujete u aktivnostima u okviru RC-a?
6. Koje vrste kurseva i tema bi vas najviše zanimalo? Kako biste željeli da se ovaj koledž poveže s uslugama mentalnog zdravlja koje već koristite, ili ste ih koristili u prošlosti?
7. Šta za vas znači da je neka usluga "koprodukovana"? A šta bi značilo da je "vođena od strane korisnika/vršnjaka"?

##### IMPLEMENTACIJA I ODRŽIVOST

8. Šta bi, po vašem mišljenju, bile najvažnije stvari koje bi koledž trebao imati kako biste se osjećali sigurno i podržano?

## **B) Stručnjaci za mentalno zdravlje (Intervju)**

### KONCEPTUALIZACIJA OPORAVKA

1. Šta za vas znači "oporavak"?
  - a. Kako biste opisali razliku između kliničkog i ličnog oporavka?
  - b. Koristite li ne-terapijske modele oporavka? Da li ste čuli za neke?

### TREKUTNO STANJE (POSTOJEĆE USLUGE, ZAJEDNICA, STIGMA I INKLUZIVNOST)

2. Koje usluge ne postoje, a smatrate da bi trebalo da postoje? Da li vaše klijente upućujete na usluge mentalnog zdravlja u zajednici?
  - a. Gledano dugoročno, u kojoj mjeri postojeći servisi podržavaju proces oporavka stručnjaka po iskustvu?
3. Koje prepreke vidite za učešće osoba u servisima mentalnog zdravlja u zajednici? Kako se stigma manifestuje u vašoj zajednici i kakvi su učinci na ljude s kojima radite?
4. Koju ulogu bi, po vašem mišljenju, neklinička usluga u zajednici mogla imati u smanjenju stigme i u povećanju uključenosti?

### RECOVERY COLLEGE MODEL

5. Da li ste čuli za Recovery College model rada u mentalnom zdravlju?
  - a. Dati pojašnjenje RC

### KOPRODUKCIJA, OBRAZOVNI OKVIR I INTEGRACIJA USLUGA

6. Na koji način bi ne-klinički, edukativni pristup poput RC-a mogao koristiti osobama sa poteškoćama MZ u njihovom procesu oporavka? Da li biste želeli učestvovati u aktivnostima RC? Kakvu ulogu podrška kroz edukaciju i trening za samopomoć mogu imati u oporavku?
7. Kako vi razumijete koprodukciju u uslugama mentalnog zdravlja? Šta treba da postoji ili da se desi kako bi postojala veća saradnja između stručnjaka i ljudi s ličnim iskustvom? Kako bi stručnjaci mogli doprineti kocreiranju sadržaja RC-a?

### IMPLEMENTACIJA I ODRŽIVOST

8. Koji su najveći percipirani rizici ili izazovi u implementaciji nove usluge poput ove (recovery college)? Kako osigurati dugoročnu održivost ovakvih programa? Koja bi se postojeća sredstva ili prostori u zajednici mogli iskoristiti za podršku njegovom radu?

## **C) Građani (Fokus grupa)**

### KONCEPTUALIZACIJA OPORAVKA

1. Kada čujete riječ "oporavak" u kontekstu mentalnog zdravlja, šta vam prvo pada na pamet?

### TREKUTNO STANJE (POSTOJEĆE USLUGE, ZAJEDNICA, STIGMA I INKLUZIVNOST)

2. Da li znate za usluge mentalnog zdravlja u zajednici? Da li ste vi ili neko vama blizak koristili te usluge? Šta mislite da nedostaje?
3. Kako bi se zajednica mogla više uključiti u podršku mentalnom zdravlju?

### RECOVERY COLLEGE MODEL

4. Da li ste čuli za Recovery College model rada u mentalnom zdravlju?
  - a. Dati pojašnjenje RC

### KOPRODUKCIJA, OBRAZOVNI OKVIR I INTEGRACIJA USLUGA

5. Vjerujete li da obrazovanje može biti koristan alat za oporavak mentalnog zdravlja?
6. Koje teme bi RC trebao pokriti? Da li biste lično učestvovali u takvim edukacijama ili radionicama? Zašto da/ne?
7. Smatrate li da bi se ljudi s ličnim iskustvom mentalnih poteškoća trebali uključiti u osmišljavanje i pružanje usluga? Zašto da/ne? Šta je prepreka?

### IMPLEMENTACIJA I ODRŽIVOST

8. Koja bi se postojeća sredstva ili prostori u zajednici mogli iskoristiti za podršku njegovom radu? Kako osigurati dugoročnu održivost ovakvih programa?

## **D) Donosioci odluka (Intervju)**

### KONCEPTUALIZACIJA OPORAVKA

1. U okviru onoga što je vama poznato, vaše pozicije u ustanovi u kojoj radite kako se definiše oporavak?
2. Kako se definiše uspjeh u skrbi o mentalnom zdravlju? Postoje li neki pokazatelji (mjerenja, praćenja, drugi izvori podataka)?

### TREKUTNO STANJE (POSTOJEĆE USLUGE, ZAJEDNICA, STIGMA I INKLUZIVNOST)

3. Kako je vaša institucija povezana sa uslugama koje postoje (finansiranje, pružanje usluga, suradnja...)?
4. Da li postojeći programi mentalnog zdravlja zadovoljavaju potrebe korisnika? Koje nedostatke vidite u postojećem sistemu podrške?
5. Koje su prepreke za učešće građana u servisima za mentalno zdravlje (stigma, informiranost, socio-ekonomske teškoće, prevoz...)?
6. Da li postoje neki dokumenti ili inicijative (strategije, planovi, radne grupe...) za unaprijeđenje postojećih servisa?

### RECOVERY COLLEGE MODEL

7. Da li ste čuli za Recovery College model rada u mentalnom zdravlju?
  - a. Dati pojašnjenje RC

### KOPRODUKCIJA, OBRAZOVNI OKVIR I INTEGRACIJA USLUGA

8. Kako bi se neklinički model poput Recovery College-a uklopio u postojeći sistem pružanja usluga mentalnog zdravlja?
  - a. Da li bi mogao podržati reintegraciju ljudi s mentalnim zdravstvenim izazovima u život zajednice?
9. Kako gledate na koncept koprodukcije u trenutnim uslugama? Da li je prisutan i (ako nije) da li je moguć?
10. Koje bi politike ili okviri bili potrebni da se korisnicima usluga omogući da budu "jednaki partneri" u osmišljavanju i pružanju podrške za mentalno zdravlje?

### IMPLEMENTACIJA I ODRŽIVOST

11. Koje prepreke ili izazove predviđate u implementaciji ovog modela? Šta je potrebno kako bi imao finansijsku podršku i koji bi bili ključni pokazatelji uspeha?
12. Koja partnerstva bi bila najvažnija za uspješno i održivo funkcionisanje? Koje ciljeve bi RC trebalo da ima da bi dobio podršku?
13. Da li bi vaša institucija podržala rad Recovery college i kako bi ta podrška izgledala (deklarativno, novčano, logistički, partnerski...)?



**Balkan Recovery College**

BALKAN HEARING VOICES NETWORK

# **NEEDS ANALYSIS COUNTRY REPORT**

**Bosnia and Herzegovina**



Co-funded by  
the European Union

Erasmus+ project, 2025

## Contents

1.	Introduction	3
2.	Methodology	4
2.1	Participants	4
2.2	Instruments	4
2.3	Procedure	4
3.	Results	5
3.1	The conceptualization of recovery	5
3.2	Current conditions (services, community, stigma and inclusivity)	7
3.3	Recovery College Model	10
3.4	Coproduction, educational framework and integration of services	10
3.5	Implementation and sustainability	13
4.	Conclusion	15
	Appendix	17
	Appendix 1: Focus groups and interview questions	17

# 1. Introduction

This research was conducted as part of the Balkan Recovery College Erasmus+ project. It was done in four partner countries by local project teams in Bosnia and Herzegovina, Croatia, Slovenia and Serbia. In this report, we will focus specifically on Bosnia and Herzegovina.

The purpose of this research is to map the local needs in each country through focus groups and interviews, regarding the organizational structure and main focus of the Recovery College model. It is the second step in developing the Recovery College model for the four project countries. First step was desk research, a thorough literature review which provided a comprehensive overview of the principles, evidence base, and implementation challenges of Recovery Colleges. The desk research report also gave us direction for what to focus on in needs mapping.

Through co-production among project country teams, with the supervision of Camden & Islington NHS Foundation Trust, we derived five areas of research interest based on the previous desk research report. These are: (1) Conceptualization of recovery, (2) Current conditions (services, community, stigma and inclusivity), (3) Recovery college model, (4) Coproduction, educational framework and integration of services, and (5) Implementation and sustainability.

Each country's local project team provided a list of suggested stakeholders for focus groups and interviews, which was reviewed and approved by the whole project team. After that, we developed guidelines and questions for conducting the focus groups and interviews, all in accordance with the principles of co-production.

Results will be presented by theme and by participant group. In conclusion we will provide recommendations for further Balkan Recovery College model development.

## *Disclaimer*

*This document is committed to using inclusive, respectful, and sensitive language that upholds the dignity of all individuals. However, certain terms used in the text may not align with current standards of sensitive or person-first language. The views and terms expressed in this report do not necessarily reflect the attitudes or values of the authors, but rather those of the research participants.*

## 2. Methodology

### 2.1 Participants

In the research, we had four target groups of participants: service users, mental health professionals, citizens, and decision makers. Participants were recruited for participation through social media advertising and using the snowball technique.

A total of 3 focus groups were conducted (with 2 involving service users and 1 involving citizens), along with 5 interviews.

A total of 21 participants took part in the research, specifically: 10 service users, 5 citizens, 3 mental health professionals, and 3 decision makers.

### 2.2 Instruments

We developed guidelines and questions for conducting the focus groups and interviews, adhering to the principles of co-production (Appendix 1). Questions were adapted for each participant group to specifically reflect their experiences. For example, on the topic of recovery, service users were asked about their personal experience of recovery, while mental health professionals were asked about differences between personal and clinical recovery concepts.

Same questions were used in all project countries.

### 2.3 Procedure

The focus groups and interviews were conducted between June and September. On average, the focus groups lasted 1 hour and 30 minutes, and the interviews lasted up to 1 hour. We obtained informed consent from all participants to conduct the interviews, record them, and process the data. All interviews and focus groups were audio recorded and subsequently transcribed. These transcripts were then used for the analysis and the results presented below.

## 3. Results

Results are presented as five themes that were our focus. For each theme, we presented findings from each participant group, as well as conclusions on differences and similarities in their answers.

### 3.1 The conceptualization of recovery

For most of the **service users** „recovery” was connected to the feeling of being **functional** in everyday life. That functionality refers to being able to focus on their family, friends – to spend time with them, to be socially active, being able to work, study, have hobbies, to make decisions about their life and be active members of the community. Recovery also means having control over their body and mind, to be able to make plans, contacts, to listen to other people, to regulate emotions, and not to be in fear. Another important thing that was pointed out is the absence of crisis and enjoying everyday life. One of the service users says: *„For me, recovery includes both illness and healing, both fears and security, both isolation and the desire for the outside world. I felt that I was part of recovery when I was not afraid of my illness. That's when it almost didn't matter to me whether I would have a panic attack on public transport or anywhere in public. Recovery has something beautiful and special in it, because after difficult conditions, when I mastered my fears, satisfaction and enjoyment of life appeared.”*

When asked what helps them feel hope, identity and purpose, service users mostly highlighted social, physical and spiritual aspects. Social in terms of support groups, meeting with people, support of close people (friends, family members) and sharing through meaningful conversations. Physical in terms of being active – walking, sports, movement in general. Spiritual in terms of practicing religion. They also pointed out how the feeling of acceptance and *„being like everybody else – fitting into the society“*, gave a sense of identity and purpose, and how self-motivation was the most important thing for bringing the feeling of hope. Some members reported reading and everyday tasks (cleaning, helping other family members, doing chores) as important for their sense of purpose and hope.

Having an active role in one's recovery process is a struggle for many service users. They mostly feel like their recovery process is a destiny path, and that they can take over the active part through alternative approaches – like reading, being active, having conversations, support groups, to have hobbies. Common belief amongst service users is that doctors are in charge, and that they must respect their opinion and without questioning take prescribed medication, hoping that it will be reduced in some time. Stigma sometimes makes it even more difficult to be active in the recovery process, and having a support system helps to reduce those effects.

**Citizens** had associations rather than definitions of „recovery“, and for them it also means to be functional, to return to yourself but also to relate with others, to heal, to feel relief and to have peaceful sleep.

**Mental health professionals** define recovery through functionality and differ clinical and personal recovery in terms that *clinical does not necessarily mean functionality*, but rather absence of symptom, and personal refers to constant effort to maintain functionality and to be supported

through that process by close people. In their work they often use non-therapeutical models of recovery (activity, referring to associations that have support groups, etc), only one reported she doesn't use such models. A mental health professional who works in a psychiatric hospital says: *“There are a lot of tools that, conditionally speaking, which are not clinical, which not only I - which we all use, and which can have a benefit for certain people. Now we know that they have been proven to be good, but not necessarily to be used in clinical practice. In clinical practice, we are condemned, or to say focused, on two things: psychopharmacotherapy, psycho-supportive therapy and psychotherapy doctrine. And there are a lot of things that we rely on in the community that do not fall into these examples.”*

**Decision makers** have defined recovery as a period after a trauma, enhancement of someone's state, things that we do to reduce consequences if we cannot reduce them, social integration of the patient. They state that the process of treatment usually starts and continues in the hospital, and after stabilization it should contain psychotherapy and occupational therapy as a treatment. Also, coordinated care/discharge was mentioned, in which hospitals and mental health centres should cooperate to handle the patient's discharge and offer support to the patient after hospitalization. But as one of the decision makers says, sometimes this system doesn't work as it should: *“We are talking about three practical segments: treatment and introduction to recovery, coordinated discharge, work on individual recovery plans - case management at the level of mental health centres is how the system is designed to work. Unfortunately, we have situations in the system when everything does not work in the most optimal way.”*

## Conclusion

The definition of recovery for majority of the participants included the concept of functionality in everyday life, regarding work, family and social life, activity and making decisions. For service users, citizens and mental health professionals, clinical recovery was just a part of the process, having in mind other aspects that are defined as personal recovery. There was also an agreement for the MH professionals that clinical recovery does not necessarily mean functionality and that personal refers to constant effort to maintain functionality and to be supported through that process by close people. On the other hand, it seems that role of service users in their recovery process is more passive than active, reflected in accepting their state as given, hoping for the best, relying on the doctor's expertise and putting responsibility on themselves for self-motivation to bring the feeling of hope. For decision makers, recovery is more defined through medical models and clinical definitions, which reflect what is usually available in the public (mental) health system.

Service users and mental health professionals have also highlighted the importance of non-therapeutical aspects of recovery that are part of a person's everyday life and affect the process of recovery on many levels, as well as relying on the services in the community for supporting this process.

## 3.2 Current conditions (services, community, stigma and inclusivity)

Some services that **users** had contact with are mental health centres, hospitals (2 main ones in Sarajevo) and associations. They pointed out that our association has been meaningful for their recovery path, one of them stating: *„I would also praise the entire Tavan team, friendly people, eager to help, educated, which is the most important thing. In short, when I come here, I feel like someone cares. - that someone cares. There is still a lot to be sorted out, I would not criticize, I will not name which institutions, but I think that there should be more consideration for people with mental challenges. But I think it is good that Tavan is like some initial change, that is what I would call it.”* Few users also agreed that sometimes there is not enough consideration in some institutions, and some of them say they feel lucky their doctor is attentive to them. Regarding hospitals, one hospital is rated better than the other, because of the conditions and staff. Users say that in the lower rated hospital doctors “work like robots”, just giving medications and asking basic questions, and in the better rated one staff is kind, attentive, and medical technicians are experienced and dedicated. One of the issues with hospitalizations is the possibility of forced hospitalization, which includes police and does not give the person a choice whether they want to be hospitalized. Some of the users had that experience and state that it is the worst experience with the mental health system. Sometimes there is the issue of not taking medication, mostly because they cause lack of energy, sleepiness, weight gain, mood change and other side-effects. When it comes to mental health centres, they are pretty much satisfied with the comment that sometimes there could be more consideration towards patients.

**Mental health professionals** often refer their patients to different services, and they state that they are grateful for those services, but that sometimes the system is not working like it is proposed by documents, because there is a lack of employees in that sector, too many people in need of support, and not enough capacities. Some services that are not available and they think should be are: crisis centres for men, support groups for all kinds of difficulties, use of dialogical practices, support systems in hospitals, support systems for people addicted to digital appliances. They think that existing services somewhat support the recovery process, but they often don't have continuity, are sometimes not utilized fully, that they are not connected well, that waiting time for therapy is too long, and private therapy is too expensive. Some of the obstacles that users might have in regard of using services, from perspective of mental health professionals are loss of self-esteem, anxiety, feelings of being less worthy or unworthy, not having enough information, not enough staff in services, lack of empathy or sensibility from professionals towards users, and of course stigma. They pointed out that stigma is present and rooted in our cultural frame, and that it isolates people, and prevents them from seeking help when the problem first appears. One of the professionals stated that self-stigma is also an observed obstacle: *„So they start self-stigmatization, so that every other form of stigmatization in society, which is not at all small, is just a confirmation of those thoughts, and that absolutely cuts off any need, any first step towards some healing or*

*self-healing.*” They state that non-clinical services in the community could contribute to reducing stigma and increasing inclusion, because no matter what condition people are in, it is easier to come to a facility that is not strictly medical. Any idea and any kind of support and help that is not related to institutions and medical treatments opens space for people to understand that not everything is necessarily clinical, and that even if something is clinical, it is okay. One of them refers to the positive effect of community services: *„Well, there are many positive effects. Patients who are users of all the above services, essentially gain insight into this, first, that they are not alone, which is that depressing shift in perspective towards their illness – that they are not alone, they are not lonely. And at the end of the day, someone is ready to listen to them and help them. Which is terribly important, because they constantly have the impression that they are alone and forgotten by everyone. And that is that moment of stigma which, again, with the attitude of society towards these people, is a confirmation of that thought, which only thickens that self-isolation”.*

**Citizens** reported a few mental health services such as local health centres, private clinics, associations such as Wings of Hope, Kontakt Homini, Mentis and of course Tavan, and digital platform for finding therapists – Psihotron, and that they and/or their friends and family use those services when needed. What they think lacks about services is lack of information (about available services, psychotherapy modalities, what to expect), lack of different approaches – such as art therapy, group therapy, reduced (educated) staff and lack of empathy in staff, helpline for suicide, as well as limited availability, high prices. When it comes to enhancing support in the community, there are ideas about more individual activism and encouraging critical thinking, and ideas about having platforms or institutions that would take this process as their main goal.

*“As a society, we lack that individual activism, where we would talk more in our communities, starting with family, neighbourhood, etc. But I think that every community at the municipal level should have an institution that would deal with mental health. That would offer both therapy and workshops, just to be a safe place for both young and old. But a centre that would destigmatize the stigma that we already have around mental health, so that it wouldn't be strict about going there for psychotherapy, but also to get to know each other, to socialize and work on ourselves.”*

Institutions where **decision makers** work are connected to the services in terms of legislatives, enactment of laws, defining roles of mental health centres, monitoring the implementation of policies, working with the commission for health advisory – that cooperates with mental health centres and collects information about the situation within the municipality regarding the mental health of residents. According to the decision makers, there is more need than what can be provided through the health sector: *“Health care gets involved in those moments when there are already problems, unfortunately, although mental health centres have in their job description a certain part that they also work preventively”.* Identified shortcomings are finances, not enough education of citizens about mental health, lack of positive surroundings in the local community, lack of staff in MH centres, lack of psychologists in workplaces, lack of free services. Obstacles they observed are availability in terms of working hours (some services are not available after 4 or 5pm), difficulty to get an appointment – because there is a lot of demand and not enough professionals,

lack of information and interest in citizens, especially in young people, stigma – but they stated that stigma has reduced significantly lately and that people are less hesitant to visit psychologist even when there is no illness. For the public health sector in Federation of BiH and enhancement of services and strategies for improvement in the future, it is also directed towards children and youth, and educational sector (mostly schools) – every school in Sarajevo has a psychologist and a protocol for mental health crises. Focus is also on opening centre for prevention of illness and promotion of health in general, that would be set up at health centres in the future.

## Conclusion

Service users mostly report using services that are available in public (mental) health sector – hospitals, centres for mental health, and some associations. Important factors for hospitals are conditions and staff, so one is rated better on both. In general, there is an agreement that the quality of relationships between doctors, technicians and service users should be better – more humane, with attentiveness, kindness, dedication and more experience. Satisfaction with staff in MH centres is high but also includes comments about sometimes lacking considerations for patients. Forced hospitalization, which always includes police, is seen as the worst experience with the mental health system. Not taking medication is also an issue, and it is mostly connected to the side effects (lack of energy, sleepiness, weight gain, mood change and other).

Mental health professionals feel grateful for the existing services but understand that the system is not working as it should theoretically, lacking in continuity of care, utilization, connection of different services, availability (long waiting time, expensive private therapy), and lack of employees in the sector (too many people in need, not enough capacities). Perceived obstacles for using services are loss of self-esteem, anxiety, feelings of being less worthy or unworthy, not having enough information, not enough staff in services, lack of empathy or sensibility from professionals towards users, stigma and self-stigma. Non-clinical services in the community are seen as a way of contributing to reducing stigma and increasing inclusion, easier availability and involvement in the services that offer support.

Citizens highlight lack of information (about available services, psychotherapy modalities, what to expect), lack of different approaches offered as a way of support (art therapy, group therapy, helpline for suicide), as well as lack of educated staff and empathy in staff, and high prices for private therapy. Individual activism and encouraging critical thinking, having platforms or institutions that would take this process as their main goal is seen as important in enhancing support in the community.

Decision makers seem to be well informed in what is lacking in the system and report that there is more need than what can be provided through the health sector, also identifying stigma, finances, lack of free services, staff in MH services, psychologists in workplaces, as well as not enough education of citizens about mental health, lack of positive surroundings in the local community.

### 3.3 Recovery College Model

Out of **21** participants, only **1** heard of the Recovery College Model. A **mental health professional** said she heard about it from her coworker but couldn't remember what it was exactly about. She only knows that it stayed in her mind as something that changes a person deeply and for life.

### 3.4 Coproduction, educational framework and integration of services

**Service users** see coproduction as an opportunity to help others who have similar challenges and a way to combine and transfer resources – personal knowledge and experience with expert knowledge. They see it as a different perspective to what is available in the system, a proactive way that promotes development, potential, strength, and active role in recovery. It is seen as an alternative form of recovery, with positive view on shifting the focus from medical treatment to education. Most of the participants agreed that they would like to experience courses creatively, to enhance their skills that would support independence and everyday living. Topics that are considered interesting are wide, from skills that are needed in everyday life, to movement workshops, self-help skills, learning about alternative methods (such as meditation), and topics from psychology. One participant said: *“The one thing I would like to know more about is psychology - why certain things happen to me and how to react to them when I'm in crises and when I'm in challenging situations. It is certainly better to know about these things, how to behave, how to get out of unpleasant situations, difficulties. Other people also face these difficulties in life, but if we know how to react more to these crises, to prevent them, to reduce them, to alleviate them, so that they don't burden us so much, stiffen us, don't bind us, so that we can simply bear them better”*. Connecting the Recovery College model with faculties, other associations for psychosocial support, Ministry of Health, some organisations that would provide funding, institution and hospitals, is recognised as useful. All participants believe that coproduction can ensure progress and be useful in solving challenges of the people who would participate in courses and would gladly contribute to the process of developing and implementing courses.

At the same time, there is expressed observation or feeling of not being on the same level as the professionals, based on the previous experiences. There is also expressed belief that professionals can learn from their experiences and that they can complement each other, although, professionals are seen as having a more important role.

The idea of coproduction was rated positively by **MH professionals**, and all participants answered that they would want to be included in a programme that is created in coproduction. They all think that currently there isn't enough coproduction in the mental health system, and that people have different ideas of what it means. One of them stated: *“Things are more focused and organized in a way that I (the professional) provide support, and you (the client) are an active participant in that process. You should do what I think is necessary and more important. Although in a therapeutic relationship the client should be in an equal relationship with the therapist, I don't*

*know how much this is practiced or how other psychotherapists work. We have a long way to go, given that people don't have the idea of reflection and self-reflection".* Some of the ideas of how to have more coproduction in the system is to have it standardized and defined, raising awareness of positions within the therapeutic process among professionals, the existence of laws and work frameworks, as well as an ethics committee; supervision and raising awareness of the importance of ethics and supervision, having patient's plan at the level of health care, creating connection and having safe space. They agreed that education is an excellent approach to recovery as it helps to recognize crisis and problems, share information and experience, being more approachable as it is not defined as therapy but education, it is useful and available for everyone – not just people that experience issues and it can be a lifelong resource. In terms of what MH professionals can bring into coproduction they highlighted: lots of ideas, suggestions, experience about working with people and what are most common issues, sharing techniques for dealing with different experiences, but also their personal experience that often combines with their professional experience.

**Citizens** believe that focus on education can be useful when someone shares their experience, that it can be an opportunity to learn about challenges that others face and to develop empathy. Topics they consider important are: destigmatization of mental health, self-acceptance, awareness of one's own beliefs and values, communication with others, regulation and dealing with emotions, information about various psychological disorders (e.g. depressive-anxiety disorder, borderline disorder, etc.), family challenges, challenges at work, burnout, career counselling, assertiveness, strengthening skills that contribute to maintaining health and accepting oneself, self-help, developing skills and tools for constructively dealing with problems, getting to know oneself, creative writing, self-love also. They stated that their personal participation in such trainings or workshops depends on the following: what the program is like, i.e. what topics are covered, whether they have to pay and if so, is it too expensive, the amount of time that must be invested, flexibility, the team of people who would lead the program, the amount of available and offered information about the program itself, the existence of criteria for enrolling in the program - a certain way to "filter participants" (which can be done through administrating a questionnaire for basic introductions that would show "*the mindset of potential participants*"). When it comes to coproduction, they think that experts by experience should be included in the process of creating and implementing the program, but that MH professionals should make final decisions. Some think that MH professionals are better in transferring knowledge, especially when it comes to theory, but they would be participants in an education that is coproduced, and they believe that hearing personal experiences would be meaningful and helpful for understanding some issues people are facing. They stated: "*When we know that someone has gone through an experience, and especially since there will certainly be one of us who will find ourselves in that situation, we will look at it differently. And I think it's important as a member of society to share that empathy and hear as many experiences as possible in order to become more aware of our community and ourselves.*"

From the perspective of **decision makers**, Recovery college model could be a part of the system, and similar models in the community is mentioned (Centres for healthy aging). Some service user associations focusing on mental health already exist, they representatives were included in the policy making over the years occasionally, but the financial stability (paying taxes, employing people) is something that is seen as a challenge and there are not enough support and benefits for that, so over time they are forced to stop working. Regarding the principle of coproduction, for one it is an ideal approach theoretically, and the other two highlighted that it is a process that can't be fully equal, there is view that needs to be some sort of monitoring from the expert by practice. *„Listen, where it is implemented and where there are capacities, and resources and where they are included, they are represented to the extent that their competences allow them to be in it. One person who has a mental problem can never replace a psychiatrist. Or it can never replace a psychologist, let's face it. That would then be - a person who has mental problems treats people who have mental problems. It must be under certain supervision and under certain, I won't say control, but under certain monitoring”*. They agree that expert by experience can only participate in part of the process, with limitations, because they are not formally educated, and thus can't be “in charge” of the process. Having competence for providing support as expert by experience is important, as well as sharing their stories, but that is not seen as having the same value as support provided by experts by practice.

## Conclusion

All participant groups unanimously support the educational framework. They see it as a proactive, approachable, and non-medical alternative to therapy that builds empathy and provides lifelong skills. Furthermore, there is an agreement that co-production is currently lacking and that "experts by experience" should be involved, but there is disagreement on the definition and execution of co-production.

Service users envision a true, equal partnership, where lived experience and professional knowledge are combined, while decision makers and citizens insist on a hierarchy. They believe professionals must have final decision-making power and monitoring control, viewing lived experience as a valuable *contribution* but not equal authority. Mental Health Professionals are in the middle: they support co-production but want it "standardized," defined, and supervised, aligning more with the hierarchical view.

### 3.5 Implementation and sustainability

For **service users** Recovery college must ensure empathy, honesty, respect, sense of belonging, expertise, consideration, support from meaningful organizations and ethical codex. They also find it important to have a clearly defined responsibility, structure and work system, also people who believe in human potential and love what they do. Physical space where it would be implemented is also important, that it is comfortable and approachable, and that it is not always indoors. When it comes to continuity, they stated that a lot of programs only work if there is funding, and then when the funding is gone, people often lose that resource and are left without the support. One participant explained: *“It should ensure safety. This would mean that people with knowledge and skills in mental health should be present at the college. In such a college, it would be important to have a lot of people who have experience with mental health challenges. Activities, such as providing space or possibly covering travel expenses, are not negligible. So, at such a college, the student would only have the task of participating and not worrying about the accompanying things that I mentioned.”*

**Mental health professionals** perceive many challenges in implementing this model, such as: Where to start, Who could be interested, and How would a new model be accepted in the community. As one of them said: *“A lot of challenges, that's for sure. Any innovation takes a lot of time to be accepted and a lot of time to be implemented. And these beginnings, especially in mental health, especially in our country, are always very difficult, very tiring, demanding and very often not well accepted in the beginning”*. Other perceived challenges are stigma, MH experts or experts by experience not being interested or motivated enough, experts by experience isolating themselves (e.g. If they stopped drinking medication and had withdrawal symptoms). When it comes to sustainability, they believe that compliance with service users is very important because when there is the need for the service, it is easier to maintain it. They think that local government is the address to contact, for budget and space. Collaboration with health centres and MH centres is pointed out as important, and they think if one local community implements RC, others might follow. Also, health centres are perceived as a good focal point, as service users almost always start with health centres as their first address when seeking help. Some of the other recommendations for sustainability are - good planning of the initial design and setting of the program itself, monitoring the course of the program, monitoring people's reactions and needs, alignment with the context and needs and making corrections as necessary. Some of the existing resources in the community could be used to support the model in terms of recruiting professionals, educating and training them, sharing the program with existing institutions and organizations with the aim of applying it in their areas, sharing the program with organizations that offer free services in order to increase the number of people who would participate.

In **citizens'** opinion, existing associations that actively deal with topics of mental health are a good starting point for brainstorming on how to do something sustainable. In addition, promotion through social networks is highlighted as important, but also promotion through local communities

because of the people that are not on social media. The interest of the participants is needed, because this will be the measure of success. To ensure the long-term sustainability of such programs, they see it as important to find a concrete way to apply the acquired knowledge in practice/community, also that there are resonance and interaction with the target groups. The participants should be the ones who will ensure the sustainability of the program, because the participants are ambassadors of the project, as they said: *"I think it would be very important to find people who would promote this idea, purely because something needs to be heard of in order for it to survive."*

When it comes to implementation, **decision makers** agree that laws and finances are the key, and they recognize active advocacy as important. Laws and policies that will support coproduction and create space for peers to be equally included (as they are not now), and finances, mostly from local budgets that need to recognize this model as important for the citizens. As one of the decision makers says: *„Local budgets that will recognize such things, that will recognize that it is important to have a mental health association and that they must have some spaces where they can express themselves creatively, where they can do some things creatively and where they can show their capacities through exhibitions, through various social activities and be recognized in society, so that they can be included. But for that you must have recognition from the local community”*. Something that would show the success of this model would be satisfied citizens within the community where it is implemented. This model could, in their opinion, create space for support and inclusion of people who have lived experience, and it could be an extension of existing services, in partnerships with local community and health centres.

## Conclusion

All participants have contributed to a practical roadmap identifying implementation steps, sustainability requirements, and the primary barriers from their perspectives. There is strong consensus on how to integrate (via partnering health centers and local government, existing services), how to sustain (via continuous feedback - monitoring user needs, ensuring "resonance" with participants, and making corrections as needed), and what the main blockers are (laws and finances).

On one side, especially for service users, Recovery College must be built on values like - empathy, respect, honesty, ethics, sense of belonging and on the other the clear operational structure (defined responsibilities, work systems) is also important. Decision makers state that active advocacy is needed to change some of the existing policies and secure dedicated local budgets to make co-production a structural reality. Citizens also highlight use of social media for broad reach and local communities (offline) to include those who are not online.

## 4. Conclusion

The needs analysis results show strong consensus on the need for a Recovery College and reveals significant difference in perspectives between current services and user expectations, particularly regarding the concept of recovery and co-production.

While most participants (Service Users, Citizens, and MH Professionals) define recovery broadly as personal functionality and everyday life engagement (with clinical recovery being only a part), decision makers primarily define recovery through medical models and clinical definitions, reflecting the existing public health system's focus. Furthermore, service user's role in the recovery process appears as more passive rather than active, often defined by accepting their state as given, reflected in reliance on public services (hospitals, MH centres) MH professionals' expertise and self-motivation. MH professionals on the other hand acknowledge that clinical recovery doesn't guarantee functionality. The importance of community services in supporting the non-therapeutic aspects of recovery is also highlighted.

Stigma, self-stigma, loss of self-esteem, and lack of information, as well as lack of staff, lack of empathy from staff, lack of alternative, diverse approaches, poor continuity of care, and high cost for private alternatives, are major obstacles to recovery and involvement in services, making non-clinical community services essential for reducing barriers and increasing inclusion. Forced hospitalization is highlighted as the worst experience, followed by severe side effects of medication. All groups agree that non-clinical community services are vital for reducing stigma and increasing inclusion and availability.

Strong support for co-production, one of the main principles of Recovery College model, is evident, reflected in seeing the educational framework as a proactive, non-medical, and approachable alternative to therapy that builds empathy and life skills.

Also, all participants agree that there should be more co-production and that experts by experience must be involved, but they disagree on the model - service users highlight true, equal partnership between lived experience and professional expertise, while decision makers and citizens insist on a hierarchical model where professionals retain final authority and monitoring control. Mental health professionals fall in the middle, supporting co-production but wanting it "standardized," defined, and supervised, leaning toward the hierarchical model.

Integration with existing services and continuous feedback are highlighted, and primary and most significant barriers identified for implementation are laws and finances, requiring active advocacy to secure dedicated budgets and policy changes.

Guiding Principles are also identified, emphasizing core values empathy, respect, honesty, and a sense of belonging as well as clear operational structure with defined responsibilities, with focus on promotion, reaching all members of community via social media and offline community engagement.

**The limitations of this research** stem from the chosen methodology. The participant sample we used cannot provide a complete overview of the entire system's status within each country, nor was that our goal. Although qualitative methods lack the generalizability of quantitative approaches, they crucially offer insight into the "how" and "why."

We chose this qualitative approach specifically because of its strengths: to gain a deeper and richer understanding of the situation, drawn directly from the personal experiences of people living and working in the contexts where the Recovery College model will be implemented.

**Recommendations for further development of the Recovery College model at this moment are centred around the core principle of co-production.** Opposing views pose a significant foundational challenge to adapting the Recovery College's model, risking a failure to achieve the core values that service users prioritize, which are also in line with the principles of Recovery College.

Results show that disagreement centers on a **hierarchy of knowledge**. If the Recovery College adopts the hierarchical model favored by decision makers and citizens, lived experience risks being reduced to *tokenism* - valuable contribution but not equal authority, which would undermine the core values that are highlighted and could lead to loss of trust and disengagement from the people the RC is intended to serve.

Also, when addressing **formal governance and structure** around co-production, even though structure is necessary for implementation (as noted in the data), focusing too much on *professional control* could stifle the organic, non-medical, and proactive nature of the educational framework that all participants supported. The Recovery College would need to establish a formal operational structure that **simultaneously validates and formalizes** the lived experience without subjecting it to purely clinical/professional oversight. If the focus goes to professional monitoring and control, the RC might move more towards clinical/medical model, which could pose a risk of moving away from service users and citizens' needs (approach focused on peer support and skills-building outside of the traditional mental health system's authority structure), and would not make any changes in the current system.

The different understanding of co-production could also make advocacy more complex - it must not only secure funds but also **lobby for policy changes** that legally and structurally recognize lived experience as an **equal authority** in curriculum development, governance, and delivery, directly confronting the current legal/financial barriers.

The success of Recovery College depends on its ability to bridge this gap, establishing a model of co-production that is perceived as genuine and equal, while still meeting the structural and accountability requirements.

Further research and contact with already established Recovery Colleges could provide more insight into bridging the gaps and addressing the recognized challenges.

## Appendix

### Appendix 1: Focus groups and interview questions

#### **A) Korisnici usluga (Fokus grupa)**

##### KONCEPTUALIZACIJA OPORAVKA

1. Šta za vas lično znači "oporavak"?
  - a. Šta vam pomaže da osjetite nadu, svrhu ili identitet izvan mentalnih zdravstvenih izazova s kojima se suočavate?
  - b. Da li ste imali osjećaj kontrole nad svojim procesom oporavka u prošlosti, ili sebe vidite kao pasivnog primaoca pomoći?
  - c. Šta bi podrazumijevalo "imati aktivnu ulogu u sopstvenom oporavku"?

##### TREKUTNO STANJE (POSTOJEĆE USLUGE, ZAJEDNICA, STIGMA I INKLUZIVNOST)

2. Sa kojim servisima mentalnog zdravlja ste upoznati i kako ocjenjujete njihovu efektivnost?
3. Koje prepreke vidite za svoje učešće (npr. stigma, transport, podrška, informacije...)?

##### RECOVERY COLLEGE MODEL

4. Da li ste čuli za Recovery College model rada u mentalnom zdravlju?
  - a. Dati pojašnjenje RC

##### KOPRODUKCIJA, OBRAZOVNI OKVIR I INTEGRACIJA USLUGA

5. Koja bi bila prednost pohađanja koledža koji se fokusira na obrazovanje i životne vještine, a ne na liječenje ili terapiju? Da li biste želeli da učestvujete u aktivnostima u okviru RC-a?
6. Koje vrste kurseva i tema bi vas najviše zanimalo? Kako biste željeli da se ovaj koledž poveže s uslugama mentalnog zdravlja koje već koristite, ili ste ih koristili u prošlosti?
7. Šta za vas znači da je neka usluga "koprodukovana"? A šta bi značilo da je "vođena od strane korisnika/vršnjaka"?

##### IMPLEMENTACIJA I ODRŽIVOST

8. Šta bi, po vašem mišljenju, bile najvažnije stvari koje bi koledž trebao imati kako biste se osjećali sigurno i podržano?

## **B) Stručnjaci za mentalno zdravlje (Intervju)**

### KONCEPTUALIZACIJA OPORAVKA

1. Šta za vas znači "oporavak"?
  - a. Kako biste opisali razliku između kliničkog i ličnog oporavka?
  - b. Koristite li ne-terapijske modele oporavka? Da li ste čuli za neke?

### TREKUTNO STANJE (POSTOJEĆE USLUGE, ZAJEDNICA, STIGMA I INKLUZIVNOST)

2. Koje usluge ne postoje, a smatrate da bi trebalo da postoje? Da li vaše klijente upućujete na usluge mentalnog zdravlja u zajednici?
  - a. Gledano dugoročno, u kojoj mjeri postojeći servisi podržavaju proces oporavka stručnjaka po iskustvu?
3. Koje prepreke vidite za učešće osoba u servisima mentalnog zdravlja u zajednici? Kako se stigma manifestuje u vašoj zajednici i kakvi su učinci na ljude s kojima radite?
4. Koju ulogu bi, po vašem mišljenju, neklinička usluga u zajednici mogla imati u smanjenju stigme i u povećanju uključenosti?

### RECOVERY COLLEGE MODEL

5. Da li ste čuli za Recovery College model rada u mentalnom zdravlju?
  - a. Dati pojašnjenje RC

### KOPRODUKCIJA, OBRAZOVNI OKVIR I INTEGRACIJA USLUGA

6. Na koji način bi ne-klinički, edukativni pristup poput RC-a mogao koristiti osobama sa poteškoćama MZ u njihovom procesu oporavka? Da li biste želeli učestvovati u aktivnostima RC? Kakvu ulogu podrška kroz edukaciju i trening za samopomoć mogu imati u oporavku?
7. Kako vi razumijete koprodukciju u uslugama mentalnog zdravlja? Šta treba da postoji ili da se desi kako bi postojala veća saradnja između stručnjaka i ljudi s ličnim iskustvom? Kako bi stručnjaci mogli doprineti kokreiranju sadržaja RC-a?

### IMPLEMENTACIJA I ODRŽIVOST

8. Koji su najveći percipirani rizici ili izazovi u implementaciji nove usluge poput ove (recovery college)? Kako osigurati dugoročnu održivost ovakvih programa? Koja bi se postojeća sredstva ili prostori u zajednici mogli iskoristiti za podršku njegovom radu?

## **C) Građani (Fokus grupa)**

### KONCEPTUALIZACIJA OPORAVKA

1. Kada čujete riječ "oporavak" u kontekstu mentalnog zdravlja, šta vam prvo pada na pamet?  
TRENUTNO STANJE (POSTOJEĆE USLUGE, ZAJEDNICA, STIGMA I INKLUZIVNOST)
2. Da li znate za usluge mentalnog zdravlja u zajednici? Da li ste vi ili neko vama blizak koristili te usluge? Šta mislite da nedostaje?
3. Kako bi se zajednica mogla više uključiti u podršku mentalnom zdravlju?

### RECOVERY COLLEGE MODEL

4. Da li ste čuli za Recovery College model rada u mentalnom zdravlju?
  - a. Dati pojašnjenje RC

### KOPRODUKCIJA, OBRAZOVNI OKVIR I INTEGRACIJA USLUGA

5. Vjerujete li da obrazovanje može biti koristan alat za oporavak mentalnog zdravlja?
6. Koje teme bi RC trebao pokriti? Da li biste lično učestvovali u takvim edukacijama ili radionicama? Zašto da/ne?
7. Smatrate li da bi se ljudi s ličnim iskustvom mentalnih poteškoća trebali uključiti u osmišljavanje i pružanje usluga? Zašto da/ne? Šta je prepreka?

### IMPLEMENTACIJA I ODRŽIVOST

8. Koja bi se postojeća sredstva ili prostori u zajednici mogli iskoristiti za podršku njegovom radu? Kako osigurati dugoročnu održivost ovakvih programa?

## **D) Donosioci odluka (Intervju)**

### KONCEPTUALIZACIJA OPORAVKA

1. U okviru onoga što je vama poznato, vaše pozicije u ustanovi u kojoj radite kako se definiše oporavak?
2. Kako se definiše uspjeh u skrbi o mentalnom zdravlju? Postoje li neki pokazatelji (mjerjenja, praćenja, drugi izvori podataka)?

### TREKUTNO STANJE (POSTOJEĆE USLUGE, ZAJEDNICA, STIGMA I INKLUZIVNOST)

3. Kako je vaša institucija povezana sa uslugama koje postoje (finansiranje, pružanje usluga, suradnja...)?
4. Da li postojeći programi mentalnog zdravlja zadovoljavaju potrebe korisnika? Koje nedostatke vidite u postojećem sistemu podrške?
5. Koje su prepreke za učešće građana u servisima za mentalno zdravlje (stigma, informiranost, socio-ekonomske teškoće, prevoz...)?
6. Da li postoje neki dokumenti ili inicijative (strategije, planovi, radne grupe...) za unaprijeđenje postojećih servisa?

### RECOVERY COLLEGE MODEL

7. Da li ste čuli za Recovery College model rada u mentalnom zdravlju?
  - a. Dati pojašnjenje RC

### KOPRODUKCIJA, OBRAZOVNI OKVIR I INTEGRACIJA USLUGA

8. Kako bi se neklinički model poput Recovery College-a uklopio u postojeći sistem pružanja usluga mentalnog zdravlja?
  - a. Da li bi mogao podržati reintegraciju ljudi s mentalnim zdravstvenim izazovima u život zajednice?
9. Kako gledate na koncept koprodukcije u trenutnim uslugama? Da li je prisutan i (ako nije) da li je moguć?
10. Koje bi politike ili okviri bili potrebni da se korisnicima usluga omogući da budu "jednaki partneri" u osmišljavanju i pružanju podrške za mentalno zdravlje?

### IMPLEMENTACIJA I ODRŽIVOST

11. Koje prepreke ili izazove predviđate u implementaciji ovog modela? Šta je potrebno kako bi imao finansijsku podršku i koji bi bili ključni pokazatelji uspeha?
12. Koja partnerstva bi bila najvažnija za uspješno i održivo funkcionisanje? Koje ciljeve bi RC trebalo da ima da bi dobio podršku?
13. Da li bi vaša institucija podržala rad Recovery college i kako bi ta podrška izgledala (deklarativno, novčano, logistički, partnerski...)?



**Balkan Recovery College**

BALKAN HEARING VOICES NETWORK

# **NEEDS ANALYSIS COUNTRY REPORT**

Croatia



Co-funded by  
the European Union

Erasmus+ project, 2025

## Contents

1. Introduction.....	3
2. Methodology.....	4
2.1 Participants .....	4
2.2 Instruments .....	4
2.3 Procedure.....	4
3. Results .....	6
3.1 The conceptualization of recovery .....	6
3.2 Current conditions (services, community, stigma and inclusivity) .....	8
3.3 Recovery College Model .....	10
3.4 Coproduction, educational framework and integration of services .....	12
3.5 Implementation and sustainability.....	14
4. Conclusion .....	17
Appendix .....	19
Appendix 1: Focus groups and interview questions .....	19

## 1. Introduction

This research was conducted as part of the Balkan Recovery College Erasmus+ project. It was done in four partner countries by local project teams in Bosnia and Herzegovina, Croatia, Slovenia and Serbia. In this report, we will focus specifically on Croatia.

The purpose of this research is to map the local needs in each country through focus groups and interviews, regarding the organizational structure and main focus of the Recovery College model. It is the second step in developing Recovery College model for the four project countries. First step was desk research, a thorough literature review which provided a comprehensive overview of the principles, evidence base, and implementation challenges of Recovery Colleges. Desk research report also gave us direction for what to focus on in needs mapping.

Through co-production among project country teams, with the supervision of Camden & Islington NHS Foundation Trust, we derived five areas of research interest based on the previous desk research report. These are: (1) Conceptualization of recovery, (2) Current conditions (services, community, stigma and inclusivity), (3) Recovery college model, (4) Coproduction, educational framework and integration of services, and (5) Implementation and sustainability.

Each country's local project team provided a list of suggested stakeholders for focus groups and interviews, which was reviewed and approved by the whole project team. After that, we developed guidelines and questions for conducting the focus groups and interviews, all in accordance with the principles of co-production.

Results will be presented by theme and by participant group. In conclusion we will provide recommendations for further Balkan Recovery College model development.

### *Disclaimer*

*This document is committed to using inclusive, respectful, and sensitive language that upholds the dignity of all individuals. However, certain terms used in the text may not align with current standards of sensitive or person-first language. The views and terms expressed in this report do not necessarily reflect the attitudes or values of the authors, but rather those of the research participants.*

## 2. Methodology

### 2.1 Participants

In the research, we had four target groups of participants: service users, mental health professionals, citizens, and decision makers. Participants were recruited for participation through social media advertising and using the snowball technique.

A total of 3 focus groups were conducted (with 2 involving service users and 1 involving citizens), along with 4 interviews (1 interview in written form).

A total of 24 participants took part in the research, specifically: 14 service users, 6 citizens, 3 mental health professionals, and 1 decision maker.

The participant sample is characterized by a broad age span of 45 years, ranging from 24 to 69. The largest proportion of participants are middle-aged adults (35–54 years), making up nearly two-thirds of the sample. Younger participants ( $\leq 34$  years) and older participants (55+ years) are represented to a lesser extent, together accounting for just over one-third of the sample. Gender distribution is skewed towards females, who constitute two-thirds of participants, while males represent one-third. Overall, the demographic profile shows a predominance of middle-aged females. They represent 41.7% of the entire sample (10 out of 24).

The sample is almost evenly divided between employed and unemployed participants, with unemployed making up a slightly larger share (45.8%). A smaller proportion (12.5%) are retired.

Participants came from diverse occupational backgrounds. The largest groups were in health and social care and skilled trades and services. Business and administrative roles, technical and engineering professions, and science/technology were also represented. A notable share of participants was outside the workforce, including unemployed and retired.

### 2.2 Instruments

We developed guidelines and questions for conducting the focus groups and interviews, adhering to the principles of co-production (Appendix 1). Questions were adapted for each participant group to specifically reflect their experiences. For example, on the topic of recovery, service users were asked about their personal experience of recovery, while mental health professionals were asked about differences between personal and clinical recovery concepts.

Same questions were used in all project countries.

### 2.3 Procedure

The study employed a qualitative design combining focus groups, individual interviews, and interviews in written form as data collection methods. This approach allowed for the exploration

of collective perspectives while also capturing personal insights, resulting in a comprehensive understanding of participants' needs.

The focus groups and interviews were conducted during September 2025. On average, focus groups lasted 90 minutes, whereas interviews ranged from 30 to 60 minutes, with a mean duration of about 40 minutes. Written informed consent, available in both Croatian and English, was obtained from all participants prior to conducting focus groups and interviews, as well as for recording and data processing. Interviews and focus groups were audio recorded and subsequently transcribed. These transcripts were then used for the analysis and the results presented below.

Participants also received written information about the project and the Recovery College model, and their participation was entirely voluntary, with confidentiality and anonymity assured. The study was conducted in accordance with ethical standards.

## 3. Results

Results are presented as five themes that were our focus. For each theme, we presented findings from each participant groups, as well as conclusion on differences and similarities in their answers.

### 3.1 The conceptualization of recovery

#### Summary for service users' answers

Service users described recovery as a continuous yet non-linear process of renewal, requiring persistence, resilience, and at times starting over. It was seen as a personal journey of rebuilding life, balance, and peace - sometimes defined by freedom from symptoms, happiness, and resocialization through creative work, therapy, and daily activities, and at other times supported by socialization, faith, nature, or family love and acceptance. Some community-based programs were highlighted as a place of refuge and progress compared to negative hospital experiences, offering group activities, art, volunteering, exercise, and social connections that foster hope, purpose, and identity. Hope was grounded in family, spirituality, and everyday goals, though some stressed it must also come from within. Experiences with control over recovery varied: while many initially felt passive and dominated by medication or hospitalization, most emphasized developing greater agency over time - accepting responsibility, setting boundaries, pursuing personal goals, resuming daily responsibilities, and making independent choices. Ultimately, recovery was understood as requiring both self-effort and supportive community connections.

*“Recovery for me is when you are herding a flock of sheep and they scatter; then recovery is when they all return back, straight into the pen where you lead them. I have been here for several years and currently in the residential community, and it is nice for me. For now, I am very satisfied with recovery and with all the people here. I think that if it hadn't been for this place, I wouldn't be here today either.” (DB, service user)*

#### Summary for mental health professionals' answers

Recovery is understood as an ongoing, dynamic process in which a person gradually improves through activities and experiences, rather than following a linear path. It includes the ability to live and function within the community despite symptoms, with illness no longer significantly hindering social or daily life. Recovery encompasses rehabilitation, achieving goals, independence, and meaningful everyday functioning. Mental health professionals distinguish between clinical recovery, which is a theory-based and medically guided process focused on reducing symptoms through treatment and professional support, and personal recovery, which is an internal, self-defined journey involving self-work and society's acceptance of diversity. To support recovery, professionals use a wide range of creative methods - including art, music, drama, play, and improvisation - adapting activities to the individual needs of clients.

*“The recovery process – essentially a period during which a person, through various activities and experiences, gradually becomes better and better. I would say that recovery is something ongoing, a process when a person reaches a better state than they were before. (...) Recovery – I wouldn’t call it linear, but rather winding, very much alive, moving from situation to situation, and it is something mostly hidden from the naked eye.” (SJ, art therapist)*

### Summary for citizens’ answers

Citizens described recovery as a long and continuous process that requires love, patience, and acceptance of change, recognizing that life may not return to its original state but can still be lived functionally. They associated it with independence and community functioning, as well as with periods of rest and withdrawal until stability is regained. Recovery was also seen as involving persistence in treatment, physical activity, and tailored methods, ultimately representing a positive process of returning to a better level of functioning.

*“I would add that a lot of love, patience, and acceptance of the changes that have occurred is needed. It will not, perhaps ever, return to the original settings, but life can be carried out functionally.” (VC, retiree)*

### Summary for decision makers’ answers

Decision-makers view recovery in mental health as increased self-confidence, optimism, recognition of life’s meaning, and improved daily functioning. They define it as personal empowerment and self-management that enable individuals to achieve goals and feel part of the community, even when symptoms persist. Mental health care was described as insufficiently effective, with better outcomes dependent on early recognition, timely treatment, and stronger coordination across systems such as health care, social care, education, police, and the church. While some quantitative and qualitative indicators are known, they highlighted a lack of robust evaluations of existing programs.

*“A state of personal empowerment and self-management that leads to the achievement of personal goals, a life that has meaning, and a sense of belonging to the community, regardless of whether the person still has certain symptoms of mental health challenges.” (KM, head of a health and social services department)*

**Conclusion:** Across all four groups, recovery was described as a continuous and non-linear process, centred on personal growth, renewed functioning, and community integration. Service users and citizens emphasized persistence, acceptance, and the role of family, spirituality, and community programs in fostering hope, while mental health professionals distinguished between clinical and personal recovery, underlining the importance of creative, individualized methods. Decision-

makers highlighted empowerment, self-management, and intersectoral coordination, pointing to systemic gaps in evaluation and service effectiveness. A key similarity across groups is the recognition that recovery extends beyond symptom reduction to include social connection, independence, and meaningful activity, while differences lie mainly in focus: users stress lived experiences and agency, professionals emphasize therapeutic and creative tools, citizens underline love, patience, and community acceptance, and decision-makers call for stronger systems and early interventions. Taken together, the findings suggest that recovery is multifaceted, requiring both individual effort and systemic, community-based supports that integrate medical, social, and personal dimensions.

### 3.2 Current conditions (services, community, stigma and inclusivity)

#### Summary for service users' answers

Service users described accessing a range of mental health services. While medical treatment and psychiatry were sometimes seen as essential, consultations were often brief and heavily focused on medication. In contrast, service users placed much greater value on community-based services - particularly art, support groups, and creative workshops - which they viewed as safe, supportive spaces for self-expression, confidence-building, and peer connection. At the same time, they highlighted major barriers to participation: lack of information about available services, limited professional capacity, and an overdependence on medication. Stigma emerged as one of the greatest challenges, both from society and within themselves, often leading to shame, withdrawal, and fear of judgment. Family reactions could intensify these difficulties, with some family members hiding or minimizing the illness, while professionals were sometimes dismissive. Despite these obstacles, users emphasized that community services play a vital role in filling gaps left by the clinical system, offering opportunities for creativity, learning, social connection, and a sense of belonging.

*“Eighty percent of people are ashamed to say that they are psychiatric patients because they reject you with words like: “Leave her, she’s crazy.” I remember when about four—no, six or seven years ago, after being hospitalized, I came here... I didn’t want to contact anyone, not even my friends. For a couple of years, I didn’t get in touch, so they called my husband: “Where is \_\_, where is she, she’s nowhere to be found?” He answered them not to be upset, that I wasn’t well, that I would call them when I felt better. And then one day a friend called me and said: “\_\_, where are you, how come you’re nowhere to be found? I haven’t seen you in years! Where are you hiding?” And then I told her, and she said that she had suspected it, that this had happened to me. (...) I didn’t want to call a single friend because I was ashamed of what they would say to me. She told me that they understood and thought that they too wouldn’t have called if they had been in my place. I was glad that they thought that way. (...) Since then, two or three times a year we go out for lunch or dinner, and we talk.” (MK, service user)*

### Summary for mental health professionals' answers

Mental health professionals emphasized that community-based services remain insufficient, particularly beyond traditional clinical care, noting the lack of family support programs, post-hospitalization services, employment opportunities, and organized housing solutions. In many settings, support is minimal or absent, leaving professionals to provide help without continuity once patients return home, which often perpetuates cycles of dependency. They identified stigma, limited education, and inadequate services as major barriers to recovery, with stigma expressed both subtly and openly, reinforcing shame and discouraging help-seeking. Professionals stress that non-clinical community services - workshops, creative projects, and social activities - can reduce stigma by fostering direct contact, which is the most powerful way to challenge stereotypes. They further highlight that mediators such as employers, clubs, or organizations could bridge users and the wider public, making services more accessible and less stigmatizing, while also building confidence, independence, and inclusion. Overall, they argue that expanding and diversifying community-based services is essential to strengthen recovery, promote independence, and reduce reliance on hospital-based care.

*„I've encountered two types of stigmas. (...) We accept them, we know they're okay and harmless, but they are pitiful, not able to do anything. (...) People are shocked when they hear where I work, how I can do that. (...) People create their own picture, which is not realistic, they know too little about it. “(LM, psychologist)*

### Summary for citizens' answers

Citizens emphasized that awareness of community-based mental health services is limited, fragmented, and often only gained when a family member becomes ill, with two participants speaking as relatives of people with lived experience. Most described poor visibility of available support, especially compared with foreign public campaigns, and noted that stigma - particularly among men - remains a major barrier to help-seeking. Schools were viewed as unprepared to address problems such as depression, self-harm, and bullying, while the Internet was described as a harmful influence on children without adequate guidance. Participants stressed the need for clear public campaigns using posters, television, and social media, including efforts directed at young people, and suggested restricting betting advertisements in favour of mental health promotion. Schools and workplaces were identified as important settings for support, with proposals for school physicians, regular checks, and workplace initiatives. Overall, citizens called for systematic and proactive community efforts to reduce stigma, strengthen awareness, and ensure early detection and accessible support.

*“All generations are harmed by today's lifestyle.” (VC, retiree)*

### Summary for decision makers' answers

Decision-makers reported that the local authority actively supports mental health services through cooperation, co-financing, and logistical assistance for a wide range of programs and organizations. However, they emphasized that existing services do not adequately meet users' needs due to a shortage of professionals, lack of community-based psychiatric services, high costs, stigma, insufficient information, and weak coordination across systems. Regional gaps in service provision were also noted. While some policy frameworks exist, the key national document is the Strategic Framework for the Development of Mental Health until 2030.

*“Existing mental health programs do not meet the needs of service users.” (KM, head of a health and social services department)*

**Conclusion:** All groups agreed that stigma, lack of information, and insufficient community-based services are major barriers to recovery and inclusion. Service users stressed the lived value of creative and supportive programs, professionals emphasized systemic gaps and the potential of non-clinical approaches, citizens called for awareness-raising campaigns and school and workplace-based supports, and decision-makers pointed to resource shortages and coordination challenges despite existing frameworks. Taken together, the findings underline a shared recognition of the need to expand and diversify community-based mental health services, strengthen intersectoral collaboration, and promote public awareness to reduce stigma and improve access.

## 3.3 Recovery College Model

### Summary for service users' answers

Service users stated that they had not previously heard of the Recovery College model, but once introduced, they responded with strong interest and positivity. They emphasized its value for learning new experiences, gaining understanding, and building supportive relationships, including with peers who can act as family. Participants especially appreciated the principle that people with lived experience are recognized as “experts by experience,” with their knowledge placed alongside professional expertise. Some also reflected on their own recovery, highlighting the importance of practical skills such as cooking, cleaning, and self-care for independent living when family support is absent. Overall, the Recovery College model was viewed as a promising and relevant approach to recovery.

*“Everything new that I have learned, I have learned here.” (DB, service user)*

### Summary for mental health professionals' answers

Most mental health professionals admit they are unfamiliar with the Recovery College model, yet they recognize the potential value of its core principles. One professional noted that the idea reminded her of group work where content was co-created with users, emphasizing shared ownership and collaboration. Another linked it to experiences of co-production in past projects, where professionals and people with lived experience worked together toward common goals. After being informed about the Recovery College model, mental health professionals found it useful and relevant. They viewed it as a way to move beyond medical treatment toward education, peer support, and shared learning, helping people build confidence, skills, and a more active role in community life.

*„If I may add, that's great because often when you meet a service user and say, 'Tell me about yourself,' they start with their diagnoses, with their illness. That comes first because they've been asked so many times - by psychiatry, by doctors... So, this is great, completely different, and I would say more appropriate. “(RD, occupational therapist)*

### Summary for citizens' answers

Citizens reported they were not familiar with the Recovery College model, but after being informed, they reacted positively, particularly valuing the idea that people with lived experience are recognized as experts by experience and co-create content alongside professionals.

*“In different phases of recovery, we need different supports and different kinds of learning.” (PJM, physiotherapist)*

### Summary for decision makers' answers

Decision-makers stated that they had not previously heard of the term Recovery College model of support in mental health, even when the concept was explained.

*“Until now, I have not heard of the term Recovery College model of support in mental health.” (KM, head of a health and social services department)*

Conclusion: Across service users, professionals, and citizens, there was no prior knowledge of the Recovery College model, yet all three groups reacted positively once informed, strongly valuing the recognition of lived experience and opportunities for learning, peer support, and collaboration. Decision-makers, however, remained unfamiliar with the model even after explanation, indicating a gap in awareness at the governance level. These findings suggest that while the principles of Recovery Colleges resonate widely and hold promise for service development, targeted efforts will

be needed to raise awareness among decision-makers to enable systemic support and implementation.

### 3.4 Coproduction, educational framework and integration of services

#### Summary for service users' answers

Service users emphasized the value of Recovery College model, describing it as a way to rebuild self-confidence, strengthen personal resources, and move beyond the limiting effects of diagnosis and stigma. They felt such an approach would help people set and achieve personal goals, develop practical life skills, and build supportive friendships through activities like cooking, art, singing, handicrafts, sports, nature-based workshops, and even learning about medicinal herbs. Some also noted the importance of spaces where unusual or personal experiences could be openly shared. Suggested topics ranged from managing emotions, self-love, trust, and applied psychology to everyday skills that support independence. Co-production and peer leadership were seen as essential, with participants stressing that people with lived experience can provide unique insights, model recovery without stigma, and complement professional expertise. Shared learning was described as empowering, fostering connection, mutual support, and reducing isolation, with most participants expressing interest in taking part, while a few felt they were already sufficiently integrated.

*“When a person is placed into a diagnosis, then you weaken her and simply the person loses her strength, her essence, her core. We all have our own defensive strengths, we all have our own awareness and something we have built, self-confidence is easily broken and it needs to be rebuilt again. With an emphasis on personal goals, strengths, what builds a person is definitely an advantage and helps people to recover. Whoever has lost self-confidence under such stigma, because psychiatrists treat people with lived experience through the diagnosis - because diagnosis comes first. I think this is a holistic concept where a person is built, strengthened, and continues on the path of recovery.” (AC, service user)*

#### Summary for mental health professionals' answers

Mental health professionals believe a non-clinical, educational approach like Recovery College could enhance recovery by encouraging learning, sharing experiences without stigma, and building confidence and long-term progress. It would shift focus from passivity to active participation, strengthen collaboration between users and professionals, and lead to positive outcomes. All expressed willingness to participate in such activities. They see co-production as a natural and collaborative process where professionals and people with lived experience contribute equally. They stress the importance of mutual respect, openness, and trust, with professionals guiding but not dominating. Co-production works best when it blends professional knowledge with the

authenticity of lived experience. Professionals highlight that true co-production requires seeing participants as equals.

*„Co-production as a natural, organic process that I experience in my work. Literally and metaphorically, everyone brings their experience to the table, and we play, in a way. Everyone can learn something from everyone else. And we grow together.“ (SJ, art therapist)*

### Summary for citizens' answers

Citizens agreed that education can play a valuable role in recovery, particularly when it fosters new skills, empowerment, and support from people with lived experience. They acknowledged that motivation can be a challenge, as individuals must take the first step, yet positive program experiences were seen as encouraging wider participation. Education was described as an opportunity for personal growth and confidence-building, with participants stressing the importance of targeted, evidence-based programs tailored to different needs. They suggested that Recovery College topics should be practical, engaging, and not strictly tied to diagnoses, including activities such as cooking, pet therapy, or creative workshops that build confidence and reduce fear. The involvement of people with lived experience was viewed as essential, for example through family members sharing coping strategies, while branding and presentation were considered important for making programs fun and accessible. Priority groups identified were children, youth, and parents, with workshops on internet safety, social media use, stigma reduction, and parenting support. Participants expressed willingness to take part, particularly if programs were concrete, supportive, and confidence-building. Key barriers were identified as stigma, fear of labelling, lack of information, and inconsistent practices.

*“Experience is the best source of information.” (MK, computer scientist)*

### Summary for decision makers' answers

Decision-makers viewed the Recovery College as a model that could help reintegrate people with mental health challenges into community life, with the social care system seen as the most suitable entry point given the rigidity of health care and police structures. They noted that elements of co-production already exist in current services, although the term itself is not used. To establish service users as equal partners, they emphasized the need for strategies and legal frameworks that formally recognize their role in the co-creation of services with professionals.

*“The mentioned model can support the reintegration of people with mental health challenges into community life. It would be good for this model to be incorporated into all existing systems that deal with mental health.” (KM, head of a health and social services department)*

**Conclusion:** All groups responded positively to the Recovery College model, recognizing its potential to strengthen confidence, reduce stigma, and support community integration. Service users emphasized peer leadership and practical, creative activities; professionals stressed active participation and co-production; citizens focused on accessible, evidence-based programs with priority for youth and families; and decision-makers highlighted the need for systemic frameworks to formalize co-production. Taken together, these perspectives reveal broad support for the Recovery College concept while underscoring the importance of tailoring activities to diverse needs and embedding the approach within supportive legal and institutional structures.

### 3.5 Implementation and sustainability

#### Summary for service users' answers

Service users stressed that a Recovery College should provide a safe, supportive environment grounded in trust, acceptance, confidentiality, and equality. They highlighted the importance of professional staff working alongside people with lived experience who genuinely love the work, bringing both understanding and authenticity. Practical facilities and activities such as cooking, singing, sports, creative workshops, and gardening were seen as vital, alongside everyday supports like help with money management. Service users also valued long-term continuity through reunions or ongoing connections, which would reinforce belonging and sustained support. They noted that many resources already exist and could be better used, highlighting the existing service as an example of an environment where mutual respect, shared experiences, and community foster strength and progress.

*“Everything is already here. (...) Everything already exists. This now, that we have met.” (IC, service user)*

#### Summary for mental health professionals' answers

Mental health professionals identify several challenges in implementing and sustaining new services like the Recovery College model. Among the greatest risks are limited financial resources, lack of motivated staff, accessibility of services, and insufficient infrastructure or space. Some note that professionals are often frustrated or overburdened in their current roles, which reduces their willingness to engage in additional projects, making motivation itself a critical barrier. At the same time, professionals emphasize that there is a genuine openness among users to try new approaches, provided services are accessible and affordable. Long-term sustainability would require stable funding, particularly through EU grants, local government support, and possibly partnerships with businesses or community organizations. Professionals also stress the importance of using existing community spaces for activities and raising awareness through media and public engagement to normalize and promote such initiatives. With persistence and clear evidence of benefits, they

believe these services could be widely accepted, providing relief to overstretched healthcare and social systems while strengthening recovery, independence, and inclusion for users.

*„I have an image in my mind of this recovery school. I imagine it as cheerful, with both users and professionals, but students also come to mind. Somehow, I believe young people have a freshness and the ability to bring something new, something different, that they are not weighed down. (...) Engage not only people from the system who are burdened by all those years, but also someone who sees something new, something different and an opportunity, not just limitations. “(LM, psychologist)*

### Summary for citizens' answers

According to citizens, suggested resources for supporting such programs include health, school, and academic institutions, hospitals, local community boards, and public spaces such as school gyms or cafés. They believed sustainability should be ensured through EU, state, and local funding, clear allocation of city spaces, and strong promotion via social networks and campaigns. Additional proposals included a helpline for continuous support and motivating youth to volunteer, with emphasis on consistent presence and visibility in the community.

*“High school students and university students, whose horizons are only just being opened, should absolutely be encouraged anywhere to help in any way - even making it a condition for an extra grade or bonus points, because that will motivate them to show up... And once they show up, then you can present something to them. (...) I believe this would mean much more to kids than additional school subjects.” (PJN, physiotherapist)*

### Summary for decision makers' answers

Decision-makers noted key obstacles to implementing the Recovery College model, including lack of legal regulation, hierarchical systems, and limited knowledge of such approaches. They emphasized that financial support would require overcoming these barriers and effective lobbying with policymakers. Partnerships should include decision-makers, and the model should demonstrate impact through higher recovery rates, fewer relapses, and cost reductions. The local authority expressed readiness to support Recovery College, pointing to its existing financial, logistical, and partnership support for similar initiatives such as *Mentalfest* and the *Anti-Stigma Program*.

*“For the Recovery College to gain support, it should achieve the following goals: higher recovery rates among people with mental health problems, fewer relapses, reduction of costs.” (KM, head of a health and social services department)*

**Conclusion:** All groups recognized the potential of the Recovery College model but approached it from different angles: service users prioritized safety, inclusivity, and meaningful activities; professionals focused on sustainability, staff motivation, and funding; citizens emphasized community resources, visibility, and volunteer involvement; and decision-makers highlighted regulatory frameworks, lobbying, and evidence of impact. Taken together, these perspectives suggest that successful implementation will require combining user-centred environments with sustainable financing, active community engagement, and systemic policy support.

## 4. Conclusion

Service users, mental health professionals, citizens, and decision-makers largely agree that recovery unfolds as a continuous, non-linear process that requires both personal effort and systemic support and extends beyond reducing symptoms to building confidence and independence, strengthening social ties, and taking part in community life. While stigma, lack of information, and insufficient community-based services remain common barriers, there is strong recognition of the potential of the Recovery College model to address these gaps through education, peer leadership, co-production, and creative, practical activities. Service users value safe and inclusive environments, professionals highlight sustainability and collaboration, citizens stress awareness-raising and accessibility for families and youth, and decision-makers call for regulatory frameworks, systemic coordination, and evidence of impact. Taken together, these perspectives underscore the importance of integrating lived experience with professional expertise, ensuring sustainable financing, and embedding Recovery Colleges within supportive community and policy structures to strengthen recovery, reduce stigma, and foster long-term inclusion.

The limitations of this research stem from the chosen methodology. The participant sample cannot provide a complete overview of the entire system's status within each country, nor was that the main goal. Although qualitative methods lack the generalizability of quantitative approaches, they crucially offer insight into the "how" and "why."

A qualitative approach was chosen specifically because of its strengths: to gain a deeper and richer understanding of the situation, drawn directly from the personal experiences of people living and working in the contexts where the Recovery College model will be implemented.

To make Recovery College model a recognised, community-based mental health service in Croatia and the region, legal recognition with simple national guidelines co-designed with people who have lived experience would provide clarity and consistency. Lived-experience leadership and peer-professional co-facilitation can sit at the heart of delivery. Co-produced courses work best when offered in safe, welcoming community venues, with flexible schedules and an inclusive approach that recognises diversity and responds to different cultural and practical needs. Stronger links with GPs, health and social services, employment and education providers would make referrals easier and support more joined-up care. Stable funding could be secured through a combination of national and local budgets, and EU programmes, while keeping access free for those in need. Municipalities and counties are well placed to provide venues and partnerships with libraries, cultural and sports groups, NGOs, and employers, and to lead local anti-stigma campaigns. A broad coalition of service users, families, NGOs, professionals, and local leaders can advocate for these changes and track outcomes and costs so the value of Recovery College model is clear to the public and decision-makers.

The planned visit to Camden & Islington Recovery College will provide an opportunity to observe how the model functions in practice and to explore strategies for sustainability and implementation. Learning from an established Recovery College will help deepen understanding of effective approaches to financing, partnership building, and long-term integration into local systems, offering valuable insights for adapting the model in Croatia and the region.

Further development of the Recovery College model in Croatia and the region should integrate lived experience with professional expertise to ensure inclusive and responsive services. Key priorities are reducing stigma, raising public awareness, and expanding access, particularly in rural and remote areas through online platforms or mobile outreach. Sustainability will depend on stable financing, motivated staff, and cross-sector partnerships. Embedding Recovery Colleges within legal and policy frameworks will be essential to create long-term, accessible, and effective mental health recovery services.

## Appendix

### Appendix 1: Focus groups and interview questions

#### **A) Korisnici usluga (Fokus grupa)**

##### KONCEPTUALIZACIJA OPORAVKA

1. Šta za vas lično znači "oporavak"?
  - a. Šta vam pomaže da osjetite nadu, svrhu ili identitet izvan mentalnih zdravstvenih izazova s kojima se suočavate?
  - b. Da li ste imali osjećaj kontrole nad svojim procesom oporavka u prošlosti, ili sebe vidite kao pasivnog primaoca pomoći?
  - c. Šta bi podrazumijevalo "imati aktivnu ulogu u sopstvenom oporavku"?

##### TREKUTNO STANJE (POSTOJEĆE USLUGE, ZAJEDNICA, STIGMA I INKLUZIVNOST)

2. Sa kojim servisima mentalnog zdravlja ste upoznati i kako ocjenjujete njihovu efektivnost?
3. Koje prepreke vidite za svoje učešće (npr. stigma, transport, podrška, informacije...)?

##### RECOVERY COLLEGE MODEL

4. Da li ste čuli za Recovery College model rada u mentalnom zdravlju?
  - a. Dati pojašnjenje RC

##### KOPRODUKCIJA, OBRAZOVNI OKVIR I INTEGRACIJA USLUGA

5. Koja bi bila prednost pohađanja koledža koji se fokusira na obrazovanje i životne vještine, a ne na liječenje ili terapiju? Da li biste željeli da učestvujete u aktivnostima u okviru RC-a?
6. Koje vrste kurseva i tema bi vas najviše zanimalo? Kako biste željeli da se ovaj koledž poveže s uslugama mentalnog zdravlja koje već koristite, ili ste ih koristili u prošlosti?
7. Šta za vas znači da je neka usluga "koprodukovana"? A šta bi značilo da je "vođena od strane korisnika/vršnjaka"?

##### IMPLEMENTACIJA I ODRŽIVOST

8. Šta bi, po vašem mišljenju, bile najvažnije stvari koje bi koledž trebao imati kako biste se osjećali sigurno i podržano?

## **B) Stručnjaci za mentalno zdravlje (Intervju)**

### KONCEPTUALIZACIJA OPORAVKA

1. Šta za vas znači "oporavak"?
  - a. Kako biste opisali razliku između kliničkog i ličnog oporavka?
  - b. Koristite li ne-terapijske modele oporavka? Da li ste čuli za neke?

### TREKUTNO STANJE (POSTOJEĆE USLUGE, ZAJEDNICA, STIGMA I INKLUZIVNOST)

2. Koje usluge ne postoje, a smatrate da bi trebalo da postoje? Da li vaše klijente upućujete na usluge mentalnog zdravlja u zajednici?
  - a. Gledano dugoročno, u kojoj mjeri postojeći servisi podržavaju proces oporavka stručnjaka po iskustvu?
3. Koje prepreke vidite za učesće osoba u servisima mentalnog zdravlja u zajednici? Kako se stigma manifestuje u vašoj zajednici i kakvi su učinci na ljude s kojima radite?
4. Koju ulogu bi, po vašem mišljenju, neklinička usluga u zajednici mogla imati u smanjenju stigme i u povećanju uključenosti?

### RECOVERY COLLEGE MODEL

5. Da li ste čuli za Recovery College model rada u mentalnom zdravlju?
  - a. Dati pojašnjenje RC

### KOPRODUKCIJA, OBRAZOVNI OKVIR I INTEGRACIJA USLUGA

6. Na koji način bi ne-klinički, edukativni pristup poput RC-a mogao koristiti osobama sa poteškoćama MZ u njihovom procesu oporavka? Da li biste želeli učestvovati u aktivnostima RC? Kakvu ulogu podrška kroz edukaciju i trening za samopomoć mogu imati u oporavku?
7. Kako vi razumijete koprodukciju u uslugama mentalnog zdravlja? Šta treba da postoji ili da se desi kako bi postojala veća saradnja između stručnjaka i ljudi s ličnim iskustvom? Kako bi stručnjaci mogli doprineti kokreiranju sadržaja RC-a?

### IMPLEMENTACIJA I ODRŽIVOST

8. Koji su najveći percipirani rizici ili izazovi u implementaciji nove usluge poput ove (recovery college)? Kako osigurati dugoročnu održivost ovakvih programa? Koja bi se postojeća sredstva ili prostori u zajednici mogli iskoristiti za podršku njegovom radu?

## **C) Građani (Fokus grupa)**

### KONCEPTUALIZACIJA OPORAVKA

1. Kada čujete riječ "oporavak" u kontekstu mentalnog zdravlja, šta vam prvo pada na pamet?

### TREKUTNO STANJE (POSTOJEĆE USLUGE, ZAJEDNICA, STIGMA I INKLUZIVNOST)

2. Da li znate za usluge mentalnog zdravlja u zajednici? Da li ste vi ili neko vama blizak koristili te usluge? Šta mislite da nedostaje?
3. Kako bi se zajednica mogla više uključiti u podršku mentalnom zdravlju?

### RECOVERY COLLEGE MODEL

4. Da li ste čuli za Recovery College model rada u mentalnom zdravlju?
  - a. Dati pojašnjenje RC

### KOPRODUKCIJA, OBRAZOVNI OKVIR I INTEGRACIJA USLUGA

5. Vjerujete li da obrazovanje može biti koristan alat za oporavak mentalnog zdravlja?
6. Koje teme bi RC trebao pokriti? Da li biste lično učestvovali u takvim edukacijama ili radionicama? Zašto da/ne?
7. Smatrate li da bi se ljudi s ličnim iskustvom mentalnih poteškoća trebali uključiti u osmišljavanje i pružanje usluga? Zašto da/ne? Šta je prepreka?

### IMPLEMENTACIJA I ODRŽIVOST

8. Koja bi se postojeća sredstva ili prostori u zajednici mogli iskoristiti za podršku njegovom radu? Kako osigurati dugoročnu održivost ovakvih programa?

## **D) Donosioci odluka (Intervju)**

### KONCEPTUALIZACIJA OPORAVKA

1. U okviru onoga što je vama poznato, vaše pozicije u ustanovi u kojoj radite kako se definiše oporavak?
2. Kako se definiše uspjeh u skrbi o mentalnom zdravlju? Postoje li neki pokazatelji (mjerenja, praćenja, drugi izvori podataka)?

### TREKUTNO STANJE (POSTOJEĆE USLUGE, ZAJEDNICA, STIGMA I INKLUZIVNOST)

3. Kako je vaša institucija povezana sa uslugama koje postoje (finansiranje, pružanje usluga, suradnja...)?
4. Da li postojeći programi mentalnog zdravlja zadovoljavaju potrebe korisnika? Koje nedostatke vidite u postojećem sistemu podrške?
5. Koje su prepreke za učešće građana u servisima za mentalno zdravlje (stigma, informiranost, socio-ekonomske teškoće, prevoz...)?
6. Da li postoje neki dokumenti ili inicijative (strategije, planovi, radne grupe...) za unaprijeđenje postojećih servisa?

### RECOVERY COLLEGE MODEL

7. Da li ste čuli za Recovery College model rada u mentalnom zdravlju?
  - a. Dati pojašnjenje RC

### KOPRODUKCIJA, OBRAZOVNI OKVIR I INTEGRACIJA USLUGA

8. Kako bi se neklinički model poput Recovery College-a uklopio u postojeći sistem pružanja usluga mentalnog zdravlja?
  - a. Da li bi mogao podržati reintegraciju ljudi s mentalnim zdravstvenim izazovima u život zajednice?
9. Kako gledate na koncept koprodukcije u trenutnim uslugama? Da li je prisutan i (ako nije) da li je moguć?
10. Koje bi politike ili okviri bili potrebni da se korisnicima usluga omogući da budu "jednaki partneri" u osmišljavanju i pružanju podrške za mentalno zdravlje?

### IMPLEMENTACIJA I ODRŽIVOST

11. Koje prepreke ili izazove predviđate u implementaciji ovog modela? Šta je potrebno kako bi imao finansijsku podršku i koji bi bili ključni pokazatelji uspeha?
12. Koja partnerstva bi bila najvažnija za uspješno i održivo funkcionisanje? Koje ciljeve bi RC trebalo da ima da bi dobio podršku?
13. Da li bi vaša institucija podržala rad Recovery college i kako bi ta podrška izgledala (deklarativno, novčano, logistički, partnerski...)?