

Western Australia Mental Health Commission

# Literature review to inform the development of Recovery Colleges in Western Australia

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## List of abbreviations

Abbreviation	Definition
AHA	Australian Healthcare Associates
AOD	Alcohol and Other Drugs
ASR	Age Standardised Rate
CALD	Culturally and Linguistically Diverse
FTE	Full time equivalent
GP	General Practitioner
HoNoS	Health of the Nation Outcome Scales
ILPs	Individual Learning Plans
ImROC	Implementing Recovery through Organisational Change
IRC CoP	International Recovery College Community of Practice
IT	Information Technology
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
NHMRC	National Health and Medical Research Council
NGO	Non-Government Organisation
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NSW	New South Wales
PHN	Primary Health Network
PTLLS	Preparing to Teach in the Lifelong Learning Sector
QPR	Questionnaire about the Process of Recovery
SESRC	South Eastern Sydney Recovery College
UK	United Kingdom
USA	United States of America
WA	Western Australia
WAAMH	Western Australian Association for Mental Health

# 1. Executive summary

## 1.1. Introduction

Recovery Colleges are education-based approaches to supporting mental health and wellbeing. Strongly based on principles of co-design, Recovery Colleges complement existing mental health support services by delivering self-directed recovery and learning opportunities in safe and welcoming places. They aim to close the gap in access to services for people who do not require hospitalisation, but would benefit from an opportunity to focus on improving their resilience and recovery.

In order to progress development of a Recovery College model in Western Australia (WA), an Expert Panel is being appointed to drive co-design with key Recovery College stakeholders, including consumers of mental health services, mental health service providers, families, carers and staff from Government and non-Government organisations. This literature review serves to inform the Expert Panel of best practice in Recovery College service delivery both in Australia and overseas.

### 1.1.1. Key fidelity criteria for Recovery Colleges

Advocates of the Recovery College model have developed key fidelity criteria that describe what a Recovery College is and the philosophy adopted in service delivery (Meddings et al. 2015). Based on the key fidelity criteria presented in the literature, a Recovery College is:

- **Based on educational principles:** it has a clear structure for lesson plans, courses and terms. There is a strong educational focus in all documentation and language. Students have “Individual Learning Plans”. Tutors or learning and development advisors help students with course selection. Curriculum is overseen by a Quality/Academic Board
- **Employs co-production:** everything (e.g. courses, materials, location design) is co-produced with students, with co-facilitation and co-learning a frequent occurrence
- **Strengths-based:** students and staff are not viewed with deficit in mind, e.g. students are not viewed for what is wrong with them, but for the positive qualities they bring to the Recovery College
- **Based at a physical location:** colleges have a physical location in the community that either stands alone or is co-located with an existing service. In both the UK and Australia, some are co-located alongside mental health services but most are in the community alongside other agencies, shops, and community venues. Most are designed to be like other educational colleges, with student cafeterias, computer study spaces and libraries for research
- **Person-centred:** the student chooses the courses they are interested in attending; they are not referral-based. There is no requirement for diagnosis or risk assessment
- **Progressive:** students work towards goals beyond the college and graduation, and are encouraged to take ownership of their own Individual Learning Plan (ILP) which details their personal educational goals

# 1. Executive summary

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- **Community-facing:** there is active engagement with local agencies, organisations and community colleges to co-produce relevant courses and facilitate pathways into valued roles, relationships and activities
- **Inclusive:** Recovery Colleges are for everyone – people with mental health challenges (whether using specialist services, their GP, or no services), carers, family, mental health service staff, and people from other social sector agencies. Students of all abilities, cultures, ages and experiences are welcomed.

## 1.2. A Recovery College model for WA

The geography and socio-demographic composition of WA are unique and distinct from existing locations where Recovery Colleges currently operate. With two metropolitan PHNs and one regional, rural and remote PHN encompassing seven highly diverse regions in terms of population density, the challenges are evident in developing a Recovery College model for WA. Further, the desire to develop a service delivery model focused on co-occurring mental health and AOD adds complexity, but drives opportunity for the WA Recovery College model. Analysis of the peer-reviewed and grey literature has been drawn upon to detail how the challenges of geography and socio-demographics may be overcome.

### 1.2.1. The challenge of geography

The form that existing Recovery College models take can vary, and innovative practice is beginning to emerge that aims to overcome geographical access barriers faced by those living in regional, rural and remote locations. In order to reach these populations, the development of models with the following characteristics will be advantageous:

- **A hub and spoke design:** Development of a central hub location within the metropolitan Perth area will enable access for metropolitan residents, and those with transport links to the city centre. Spoke or satellite locations can then be established in existing health and/or social service locations (e.g. NGO health organisations or adult education centres) in regional, rural or remote areas of WA to increase accessibility for these populations
- **Pop up Recovery Colleges:** Pop up Recovery Colleges are short-term, location specific Recovery Colleges that can easily mobilise to service regional, rural and remote communities. They retain many of the key fidelity criteria Recovery Colleges have, and are underpinned by the same educational practice
- **Digital modes of delivery:** There is currently a lack of research and evaluation of online modes of Recovery College delivery. This presents an opportunity for WA to innovate in this space, opening up access to regional, rural and remote populations, and catering for those who may wish to interact and engage with a Recovery College via the internet.

Developing a diverse model of this nature will rely upon the formation of strong and enduring partnerships with volunteer organisations, existing health and social services, Government and NGO services and regional, rural and remote stakeholders.

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## 1.2.2. Socio-demographic composition

Perth is increasingly culturally diverse (Perth South PHN 2017), whilst regional, rural and remote populations include relatively high proportions of Aboriginal and Torres Strait Islander people (Department of Local Government and Communities 2013). A snapshot of the population of WA is illustrated in *Table 1-1* (Public Health Information Development Unit 2018).

**Table 1-1: WA population demographics**

PHN / Area	Total population	Aboriginal population (% of total population)	People born in non-English speaking countries (% of total population)	People with high or very high psychological distress (ASR per 100 persons)
Perth North	1,055,697	14,103 (1.3%)	188,694 (18.6%)	9.5
Perth South	971,185	17,240 (1.8%)	188,416 (20.1%)	10.4
Country WA	532,069	44,058 (8.3%)	34,603 (6.7%)	9.5
WA	2,558,951	75,401 (2.9%)	411,713 (16.6%)	9.8
Australia	24,206,201	649,171 (2.7%)	4,190,925 (17.9%)	11.7

At present, there is little understanding of how Aboriginal and Torres Strait Islander people access and experience Recovery Colleges in Australia. Whilst some Colleges offer suicide prevention training related to Aboriginal and Torres Strait Islander populations, these courses are not extensively co-produced. There is an opportunity for the WA Recovery College model to demonstrate authentic co-production and co-facilitation with the Aboriginal and Torres Strait Islander community, and it should be acknowledged that through this process, adherence to existing Recovery College fidelity criteria may not be possible, nor desirable, particularly as Recovery Colleges have developed in predominantly overseas or mainstream contexts. Further, the development of a Recovery College model that is culturally secure and culturally appropriate and accessible for those with diverse backgrounds is essential. Learnings from existing Recovery Colleges in NSW that deliver courses in various languages may assist service development in WA.

## 1.2.3. Co-occurring mental health and AOD

At present there is no Recovery College that exists specifically for those living with a diagnosis of mental illness and alcohol or other drug (AOD) issues. However, there are services in Australia and abroad that deliver courses on co-occurring mental health and AOD issues which have been co-produced with consumers. As Recovery Colleges do not require students to disclose diagnoses, the Commission may wish to co-produce a course on co-occurring mental health and AOD issues, and those with a lived experience wishing to enrol can do so, irrespective of their diagnosis.



# 1. Executive summary

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## 1.3. Statement of best practice

The criteria for Recovery Colleges are prominent in the peer-reviewed and grey literature, and offer a comprehensive base with which to ground the development of the WA Recovery College model. Whilst the fidelity criteria represent existing Recovery Colleges, it should be noted that in developing new Recovery College models, the process of co-production may influence how the WA Recovery College takes shape. Further, the considerations for local context may necessitate deviation away from key fidelity criteria.

A Recovery College is based on several key principles (Meddings et al. 2015). Recovery Colleges:

- Are firmly grounded in an **educational approach**
- Are underpinned, always, by **co-production**
- Always recognise the **strengths of students**
- Have a **physical location**
- Are **person-centred**
- Are **not a replacement** for traditional mental health or AOD services, but supplement them
- Deliver a **progressive education** that works toward further study or employment
- Are **community facing**, and engage with the people, services and organisations around them
- Are **inclusive**.

By undertaking co-production processes with the community, the development of a WA Recovery College model may evolve differently in response to the unique geography and demography of the state. Adherence to these key principles should not be used as a marker for success, but they can provide an evidence-base on which the Commission can co-produce the Recovery College model for WA.

## 2. Introduction

### 2.1. Background and policy context

#### 2.1.1. Recovery Colleges

Recovery Colleges are education-based approaches to supporting mental health and wellbeing. Strongly based on principles of co-design, Recovery Colleges complement existing mental health support services by delivering self-directed recovery and learning opportunities in safe and welcoming places. They aim to close the gap in access to services for people who do not require hospitalisation, but would benefit from an opportunity to focus on improving their resilience and recovery. Recovery Colleges are now in operation in a number of countries around the world, including Australia (Meddings et al. 2015).

#### 2.1.2. Policy context

In December 2015, the WA Mental Health Commission (the Commission) released the WA Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (the Plan). The Plan outlines the optimal mix and level of mental health and alcohol and other drugs (AOD) services required to meet the needs of the WA population, and identifies the need to develop and expand local recovery services that assist and support individuals to maintain their personal recovery and live well in the community.

In late 2015, the Commission part-funded the development of a Western Australian Recovery College business model (and associated business plan), coordinated by the Western Australian Association for Mental Health (WAAMH). In 2016, an independent Recovery College of Western Australia Steering Group was formed to progress this work.

The Government of Western Australia have committed to developing Recovery Colleges in Wanneroo and on (or near) the Royal Perth Hospital site. The State Government has provided funding of \$200,000 to the Commission to develop a comprehensive model of service and business case for the establishment of Recovery Colleges in WA.

The Commission aims to progress the development of a Recovery College model through a process of co-design with consumers, families, carers and staff from government and non-government organisations. Preceding this consultation, an Expert Panel consisting of representatives from the aforementioned groups will be established.

#### 2.1.3. This document

This literature review serves to inform the Expert Panel who will use it as a basis for discussion informed by the evidence base to co-design a Recovery College model appropriate for the WA context. The WA context presents unique challenges and opportunities, including a diverse multi-cultural and Aboriginal and Torres Strait Islander population, and a geographically dispersed population including regional, rural and remote locations.

## 2. Introduction

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The literature review is structured as follows:

- **Review method:** this chapter will detail the search strategies, assessment of strength of evidence and approach to analysis and synthesis of the literature
- **Review findings:** this chapter will detail the literature review findings, and will include findings from the peer-reviewed and grey literature search strategies, an overview of key characteristics of Recovery Colleges, and a presentation of findings against the Commission's specified areas of inquiry. Findings for sub-themes are presented in the order of frequency in which they were present in the literature
- **Conclusion:** the concluding section of the literature review will discuss the literature review findings taking into consideration WA's unique context, provide suggestions for updating the current WA Recovery College Business Model and Plan, and close with a statement of best practice.

## 3. Review method

### 3.1. Search strategy

AHA conducted a search of peer-reviewed and grey literature, as well as evaluative documents available through existing Recovery College services. To be included in the literature review, articles had to specifically address Recovery Colleges as defined in *Section 2.1.1*.

The following search terms were used in each search strategy: “Recovery College\*”, “recovery education centre\*”, “wellbeing college\*” and “empowerment college\*”. The process for searching peer-reviewed literature involved:

- A separate search using Google Scholar and academic databases
- Extraction of articles into Mendeley
- Scanning of titles to identify relevant articles (based on inclusion criteria)
- Ambiguous articles had abstract and full article review to determine inclusion.

The search for grey literature utilised the same search terms as the peer-reviewed literature search, and was conducted by:

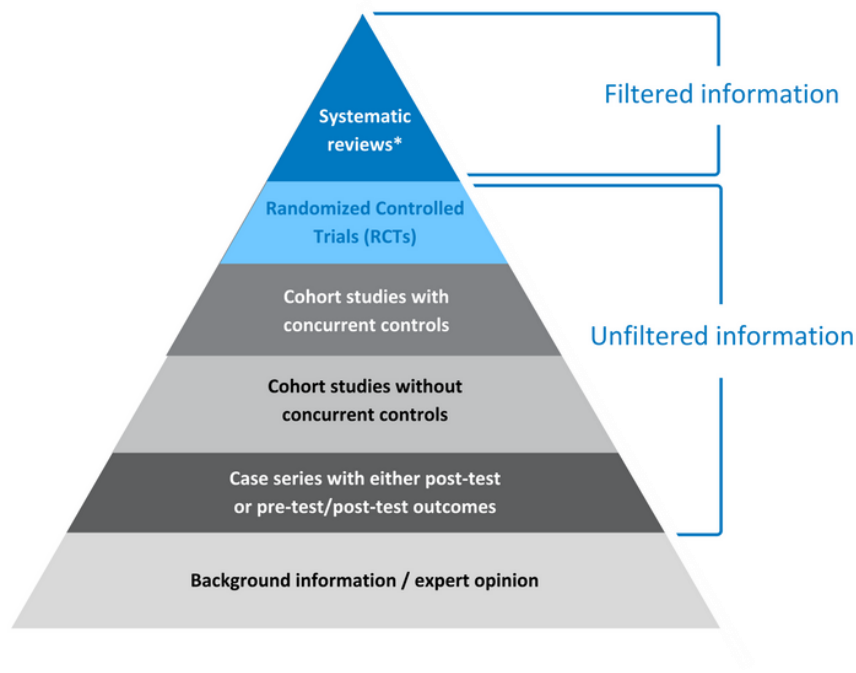
- Performing a Google search and scanning result titles
- Importing web links into Mendeley if deemed relevant to the literature review
- Progressing through Google search result pages until Recovery College related links no longer appeared.

### 3.2. Assessment of the strength of evidence

Study quality was assessed by utilising the National Health and Medical Research Council (NHMRC) evidence hierarchy guidelines (NHMRC, 2009), as illustrated in *Figure 3-1*. The NHMRC provide guidelines on how to grade the strength of research papers when conducting a literature review. The strength of evidence hierarchy ‘reflects the potential of each study or systematic review’ (p. 13) included in a literature review ‘to adequately answer a particular research question, based on the probability that its design has minimised the impact of bias on the results’ (p. 13). In the case of the present literature review, the research question broadly aims to identify the qualities of interventions in Recovery College models.

### 3. Review method

Figure 3-1: NHMRC strength of evidence hierarchy



#### 3.3. Analysis of literature

Analysis of literature was conducted in NVivo, a software package commonly used to analyse qualitative data and literature. Pre-determined coding themes were constructed within NVivo (see *Table 3-1*) and papers/articles were read and coded to the major and sub-themes. Coded text is automatically compiled into themes allowing for closer reading and contrasting of analysis between literature sources.

Table 3-1: Coding themes and sub-themes

Major themes	Student group and engagement	Service design and delivery	Models of intervention	Evaluation outcomes
Sub-themes	<ul style="list-style-type: none"><li>• Student characteristics</li><li>• Student engagement</li><li>• Service delivery: barriers and enablers</li></ul>	<ul style="list-style-type: none"><li>• Service development</li><li>• Service characteristics</li><li>• Human resources</li></ul>	<ul style="list-style-type: none"><li>• Recovery College models of intervention</li></ul>	<ul style="list-style-type: none"><li>• Service ecosystem outcomes</li><li>• Client outcomes</li><li>• Evaluation processes</li></ul>

## 4. Review findings

### 4.1. Search strategy findings

#### 4.1.1. Peer-reviewed database searches

A breakdown of search strategy results is illustrated in *Figure 4-1*. A google scholar search was performed on the designated search terms and yielded a total of 1,152 articles. 35 articles were removed for being duplicates. 1,117 article titles were then screened for relevance to Recovery Colleges, with 1,036 deemed not relevant to the inclusion criteria. 63 articles were deemed relevant to the review upon either a title or abstract screening. Upon full review of all 63 papers, a total of 45 articles were retained for analysis.

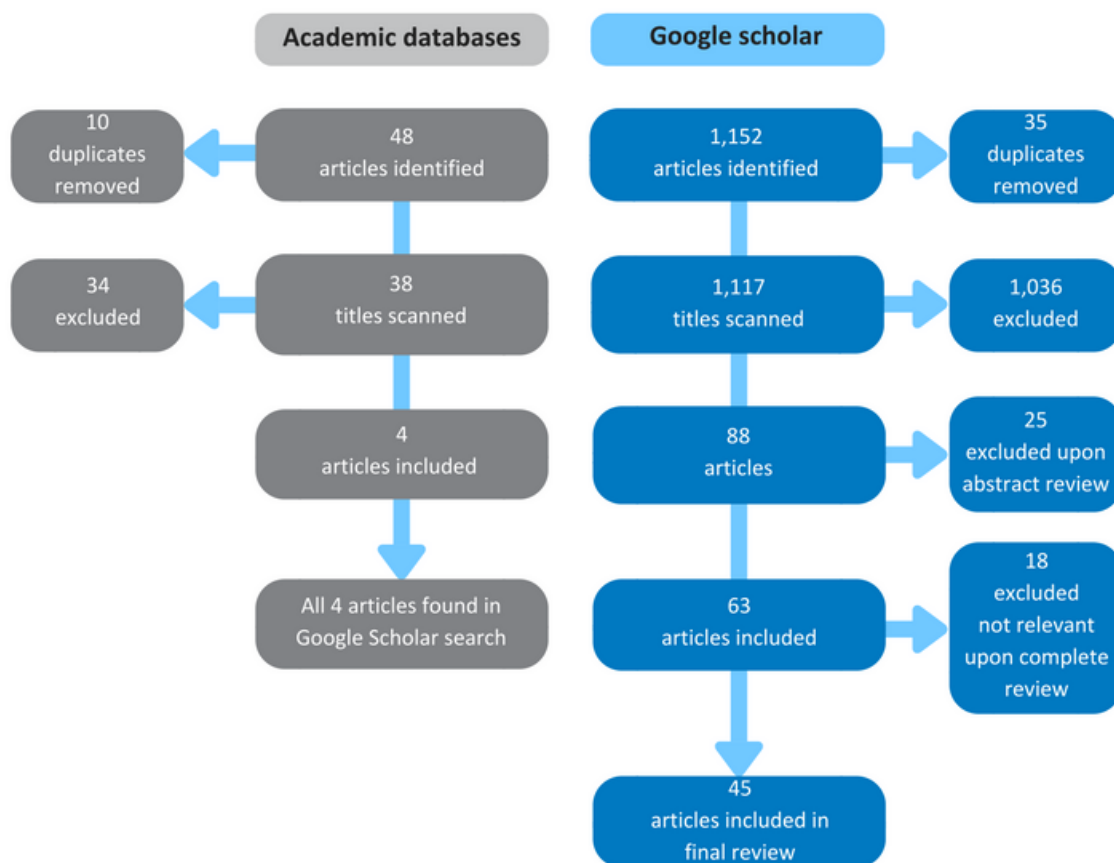
A separate search was undertaken within the following academic databases:

- PsycARTICLES
- PsycINFO
- Psychology and behavioural sciences collection
- Informit.

*Figure 4-1* illustrates the article selection process from these databases. A total of 48 articles were returned from searches across all four databases, in which 10 were identified as duplicate articles and removed. 38 articles had their titles scanned for relevancy to the literature review, of which 34 were excluded for not having content related to Recovery Colleges. This left a total of four articles from the databases searched. All four articles had been identified through the Google Scholar search, leaving a grand total of 45 peer-reviewed articles for inclusion in the literature review.

## 4. Review findings

**Figure 4-1: Literature search results**



### 4.1.2. Grey literature and existing service searches

#### Phase 1: Australian literature search

As depicted in *Figure 4-2*, results from two separate, slightly differing google searches had link titles scanned up to (and including) Google search result pages 11 and 15 respectively. Results beyond these pages did not appear to include relevant Recovery College information. The two searches identified 38 and 16 references, as well as the names and locations of 11 existing Australian Recovery Colleges. A UK database, Mind Recovery Net, was identified which listed all Recovery Colleges in the UK as at 2017. A breakdown of search strategy results is illustrated in *Figure 4-2*.

For the first search, 38 references were identified up to page 11 of the Google search, while the second search identified 16 references up to page 15 of the Google search. Existing Recovery College websites were also scanned for relevant information, producing 39 relevant articles for inclusion. This search process generated 93 references in total, of which seven were duplicates from the peer-reviewed literature and 54 were deemed not relevant upon full review.

#### Phase 2: International literature search

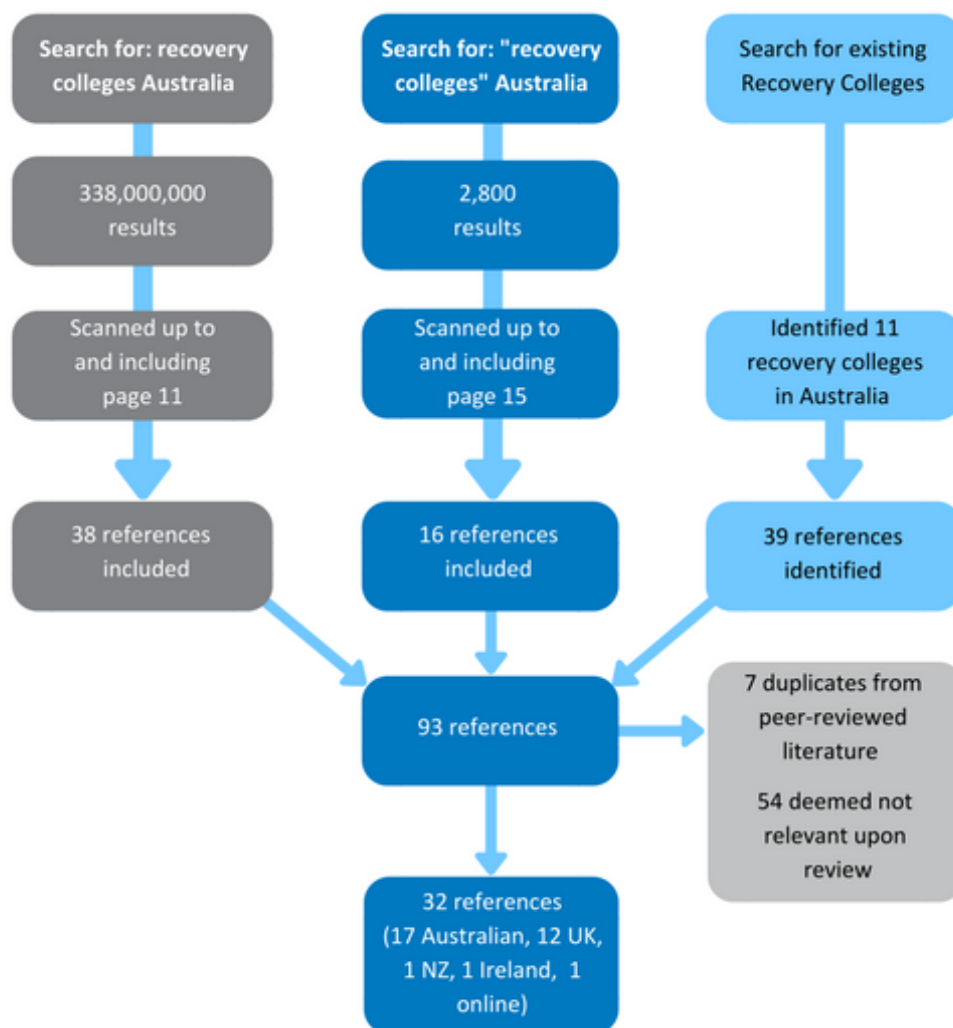
A google search was performed on the designated search terms: ("Recovery Colleges" AND "United Kingdom" OR "Canada" OR "New Zealand" OR "USA"). The UK, Canada and New Zealand were included due to their health systems sharing similarities with Australia's. The USA was included as Recovery

## 4. Review findings

College principles had originated in the USA. Similar to the grey literature search for international literature, searches were conducted to identify relevant conference papers/proceedings, annual reports, evaluation reports, newsletters, government documents, surveys, articles and pamphlets. Search strategy results for this phase are also displayed in *Figure 4-3*.

The international grey literature search strategy generated 23,200 results, of which the first 16 pages of the Google search had their web links scanned. This resulted in 32 references being recorded, of which one had been identified in the previous grey literature search and ten had been identified in the peer-reviewed literature search. A total of 21 references were retained from this search strategy for analysis.

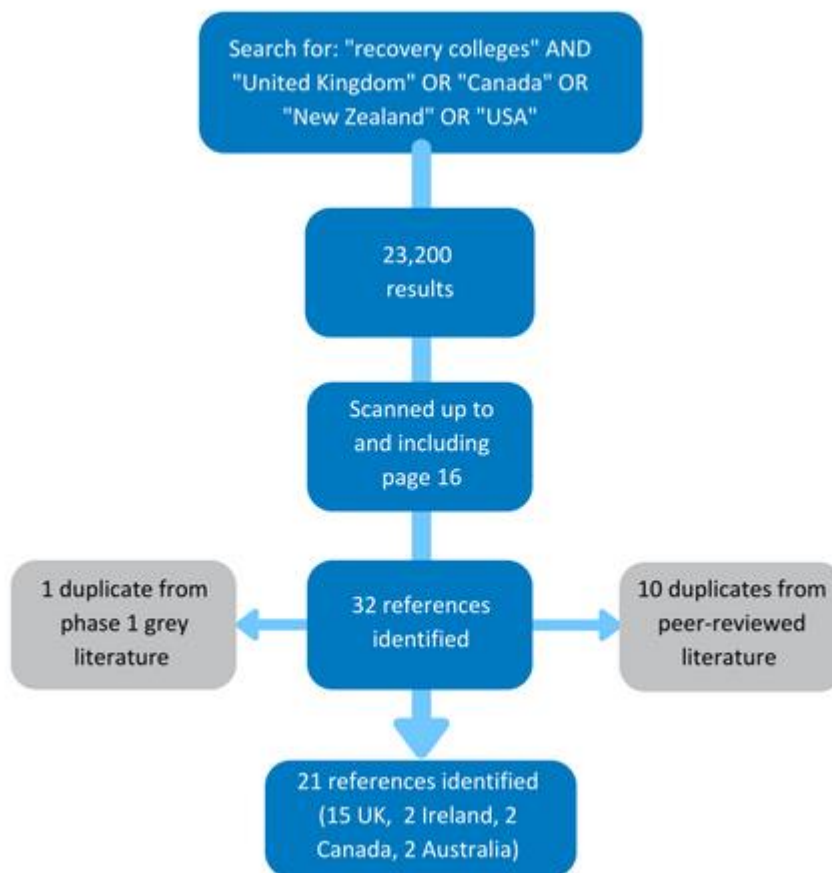
**Figure 4-2: Grey literature and existing service phase 1 search**





## 4. Review findings

**Figure 4-3: Grey literature search phase 2**



One article (Perkins et al. 2018) was included after the search had been completed in February 2018. The article was published online on March 5<sup>th</sup> 2018. This article is not reflected in the search results above.

### 4.1.3. Identified articles and coded themes

All articles were coded for major themes and sub-themes consistent with the Commission's specified areas of inquiry. *Table 4-1* displays the peer reviewed literature search and high-level coding results. *Table 4-2* displays the grey literature search and high-level coding results. Service design and delivery was the most frequently discussed theme in the peer-reviewed and grey literature, followed by evaluation outcomes.

## 4. Review findings

**Table 4-1: Peer-reviewed literature search coding results**

Title	Author(s)	Year	Place published	Student group and engagement	Evaluation outcomes	Models of intervention	Service design and delivery
"The college is so different from anything I have done". A study of the characteristics of Nottingham Recovery College	McGregor; Repper; Brown	2014	UK	✓	✓	✓	✓
A college for recovery: Co-production in action	Stein-Parbury; Gill	2014	UK				✓
A Recovery College in Canada: An Innovative Means of Supporting and Empowering Individuals with Severe Mental Illness	Arbour; Stevens	2017	Canada	✓		✓	✓
A report on the early outcomes of the Mind Recovery College™	Hall; Brophy; Jordan	2016	Australia	✓	✓		✓
A voyage of discovery: setting up a Recovery College in a secure setting	Frayn; Duke; Smith; Wayne; Roberts	2016	UK	✓	✓	✓	✓
Addressing Inclusion: Developing an innovative technology assisted learning package for educators and students for use in a UK Recovery College	Williams	2016	UK			✓	
An evaluation of service use outcomes in a Recovery College	Bourne; Meddings; Whittington	2017	UK	✓	✓	✓	
Are Recovery Colleges socially acceptable?	Thornhill; Dutta	2016	UK	✓	✓		
Barriers to attendance at Recovery Colleges	Dunn; Chow; Meddings; Haycock, Lissa	2016	UK	✓			✓
Becoming a recovery-oriented practitioner	Roberts; Boardman	2014	UK			✓	
Building Capacity in Mental Health Services to Support Recovery: An exploration of stakeholder perspectives pre and post Intervention	Watts; Downes; Higgins	2014	UK		✓	✓	✓
Building resilience for mental health recovery: A Recovery College collaboration.	Cameron; Reardon	2016	UK		✓		✓
Care co-ordinators attitudes to self-management and their experience of the use of the South West London Recovery College	Rinaldi; Suleman	2012	UK	✓	✓	✓	✓

## 4. Review findings

Title	Author(s)	Year	Place published	Student group and engagement	Evaluation outcomes	Models of intervention	Service design and delivery
Central and North West London NHS Foundation Trust's (CNWL) Recovery College: the story so far...	Zucchelli; Alois; Skinner	2013	UK	✓	✓	✓	✓
Co-delivered and co-produced: creating a Recovery College in partnership	Meddings; Byrne; Barnicoat; Campbell; Locks	2014	UK	✓	✓		✓
Developing a Recovery College: a preliminary exercise in establishing regional readiness and community needs	Kelly; Gallagher; McMahon	2017	UK	✓		✓	✓
Establishing a Recovery College in a Scottish University	McCaig; McNay; Marland; Bradstreet; Campbell	2014	UK		✓	✓	✓
Establishment of the Mind Recovery College: a concept paper	Mind Australia	2012	Australia			✓	✓
Evaluation of the Mid Essex Recovery College January–April 2014	Secker	2014	UK	✓	✓		
Evaluation of the mid Essex Recovery College, October–December 2013.	Secker; Wilson	2014	UK	✓	✓	✓	✓
Exploring the impact of the recovery academy: a qualitative study of Recovery College experiences	Zabel; Donegan; Lawrence; French	2016	UK	✓	✓		✓
Exploring the use of a Recovery College for older people with dementia in the UK	Duff	2016	UK	✓	✓		✓
From service user to student: The benefits of Recovery Colleges	Meddings et al	2015	UK	✓	✓		✓
Hope headquarters~ Recovery College	Jay; Macadam; Gardner; Mahboub	2017	Australia		✓	✓	✓
I feel like a real person and not a diagnosis' the Mind Recovery College, a new space for discourse and working together for recovery	Hardy	2016	Australia			✓	✓
Impacts of attending Recovery Colleges on NHS staff	Perkins et al	2017	UK	✓	✓		
Introducing a Recovery Education Centre for Adults Experiencing Mental Health Challenges and Housing Instability in a Large Urban Setting	Chung; Curwood; Thang; Gruszecki	2016	Canada	✓	✓		✓

## 4. Review findings

Title	Author(s)	Year	Place published	Student group and engagement	Evaluation outcomes	Models of intervention	Service design and delivery
Mental health and new models of care	Naylor; Taggart; Charles	2017	UK	✓	✓	✓	✓
Recovery Colleges	Perkins; Repper; Rinaldi	2012	UK		✓	✓	✓
Recovery Colleges – safe, stimulating and empowering.	Windsor; Roberts; Dieppe	2017	UK	✓	✓		✓
Recovery Colleges International Community of Practice Proceedings of June 2015 Meeting	Mcgregor; Hoban	2015	UK		✓	✓	✓
Recovery Colleges, co-production in action: The value of the lived experience in	Gill	2014	Australia	✓	✓		✓
Recovery Colleges: quality and outcomes	Meddings; McGregor; Roeg; Shepherd	2015	UK	✓	✓	✓	✓
Recovery Education College: A Needs Analysis	McMahon; Wallace; Kelly; Egan	2014	UK				✓
Recovery in England: Transforming statutory services	Perkins; Slade	2012	UK				✓
Recovery: a carer's perspective	Machin; Repper	2013	UK				✓
Results of an Innovative University-based Recovery Education Program for Adults with Psychiatric Disabilities	Dunn et al	2008	USA	✓	✓	✓	✓
South Essex Recovery College Evaluation	Kaminskiy; Moore	2015	UK	✓	✓		✓
Student perspectives: Recovery College experience	Meddings; Guglietti; Lambe; Byrne	2014	UK	✓			✓
Supporting recovery in mental health services: Quality and Outcomes	Shepherd; Boardman; Rinaldi; Roberts	2014	UK		✓		
The pedagogy of Recovery Colleges: clarifying theory	Oh	2013	UK			✓	

## 4. Review findings

Title	Author(s)	Year	Place published	Student group and engagement	Evaluation outcomes	Models of intervention	Service design and delivery
The RECOLLECT Project: first steps in the scientific evaluation of Recovery Colleges	Jennings; Toney; Slade; Bates; Taylor	2017	UK		✓		✓
The Recovery College: A unique service approach and qualitative evaluation	Newman-Taylor et al	2016	UK				✓
Walking side-by-side: Recovery Colleges revolutionising mental health care	Sommer; Gill; Stein-Parbury	2017	Australia		✓		✓
Why make the effort: Exploring Recovery College engagement	Harper; McKeown	2017	UK	✓	✓		
			Total references to themes	26	32	20	36

## 4. Review findings

**Table 4-2: Grey literature search results**

Title	Author(s)	Year	Place Published	Student group and engagement	Evaluation outcomes	Models of intervention	Service design and delivery
Addressing the barriers to employment: Maximising the role of Recovery Colleges	Kempton, J	N/A	UK			✓	✓
Advancing Recovery in Ireland: A guidance paper on implementing organisational and cultural change in mental health services in Ireland	Health Service Executive; Advancing Recovery in Ireland	2016	Ireland	✓			✓
An Evaluation of the Greenwich Recovery College	Wels, J	2016	UK	✓	✓		✓
ALA Forum 2016 Community based adult learning, health and wellbeing at a Recovery College	Nunley, A; Stott, S	2016	Australia		✓		✓
Annual Report 2011 – 2012 South West London Recovery College	Rinaldi; Marland; Wybourn	2012	UK	✓	✓	✓	✓
Building capacity in mental health services to support recovery. An exploration of stakeholder perspectives pre and post intervention	Watts, M; Downes, C; Higgins, A	2014	Ireland	✓	✓		✓
CNWL recovery and wellbeing college: annual report April 2014-July 2015	Skinner; Bailey	2015	UK	✓	✓	✓	✓
Coaching for recovery: a quality improvement project in mental healthcare	Burhouse, A; Rowland, M	2015	UK	✓	✓	✓	✓
Co-Producing the Journey to Recovery - The Mind Recovery College	Hall, T; Brophy, L;	2016	Australia		✓		
Developing a 'model service' to support recovery in mental health -implications for providers and commissioners	Shepherd, G; King, L;	2014	UK		✓		
Digital Challenge Workshop- Innovative Technology to Support Mental Health	DHEZ	2017	UK	✓			✓
EOI Mental Health Recovery College	South Eastern Sydney Local Health District	2014	Australia				✓
Facing the axe: Recovery 'colleges' preventing a mental health crisis hit by funding crisis, campaigners warn	Camus, E; Goodchild, S	2015	UK	✓			
Five things you might like to know about Recovery Colleges	Leach, J	2015	Open University		✓		
Homeless sign up for Recovery College	Coughlan, S	2013	UK	✓		✓	
Implementing Recovery through Organisational change Recovery Colleges	Boardman, J	2012	UK				✓

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Title	Author(s)	Year	Place Published	Student group and engagement	Evaluation outcomes	Models of intervention	Service design and delivery
Introducing the SESLHD Recovery College	South Eastern Sydney Local Health District	2014	Australia				✓
ISPS UK Perspectives Winter edition	ISPS UK	2015	UK		✓		✓
Learning for recovery	Mental Health Commission of New South Wales	2014	Australia	✓	✓		✓
Mental health: Happy to enrol in college of recovery	McDonagh, M	2013	Ireland	✓			✓
Mental Health Community Coalition of the ACT Inc Annual Report	Mental Health Community Coalition ACT Inc	2017	Australia				✓
Mind Recovery College 2018 Course guide Victoria and South Australia	Mind Australia	2018	Australia			✓	✓
Ontario Shores ' Recovery College	Health Standards Organization	2017	Canada	✓	✓		
Pathways to Better Mental Health	Federation of Ethnic Communities' Councils of Australia	2015	Australia	✓	✓	✓	✓
REAL Steps - Camau Go lawn	REAL	2015	UK	✓			✓
Recovery and Mental Health: Accessing Key Social Roles	Shepherd, G	2017	UK			✓	✓
Recovery College East Prospectus Spring and Summer 2013	Cambridgeshire and Peterborough NHS Foundation Trust	2013	UK				✓
Recovery College Project Report to Stakeholders on Co-Design Workshops	Mental Health Community Coalition ACT Inc	2017	Australia			✓	✓
Recovery College - Outcomes so far	Sault, K	2014	UK	✓	✓	✓	
Recovery Colleges – bridging the gap in mental health service provision	Morgan, P	2017	UK		✓		✓
Recovery Colleges: An overview of the international experience	Ashton, L	2017	New Zealand		✓	✓	✓

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Title	Author(s)	Year	Place Published	Student group and engagement	Evaluation outcomes	Models of intervention	Service design and delivery
Recovery Colleges: Learning how to get better, together	Collaboration for Leadership in Applied Health Research and Care Oxford	N/A	UK	✓		✓	
Recovery Colleges: where they came from, how they work and whether they make a difference	Repper, J	N/A	UK	✓	✓		✓
Recovery: The Business case	Slade, M; McDaid, D;	2017	UK	✓	✓	✓	✓
Recovery in Mental Health: Global Perspectives	Schrank, B; Amering, M	2017	UK	✓			
Recovery Prospectus	Nottingham Healthcare NHS Foundation Trust	2016	UK			✓	✓
Recovery-oriented mental health models	Smith-Merry, J; Mellifont, D	2016	Australia		✓		✓
South Eastern Sydney Recovery College 2018 Term 1 Course Guide	South Eastern Sydney Recovery College	2018	Australia	✓	✓		✓
South Essex Recovery College Evaluation	Kaminskiy, E; Moore, S	2015	UK	✓	✓	✓	✓
South West London Recovery College	South West London and St George's Mental Health NHS Trust	2011	UK	✓	✓		✓
Talking Point: The new mindset on mental health	Sutton, D	2015	Australia			✓	✓
The current state of Recovery Colleges in the UK: final report	Anfossi, A	2016	UK	✓	✓		✓
The Integrated Mental Health Atlas of the South Eastern Sydney Local Health District	Furst, M; Salinas-Perez, J	2016	Australia				✓
The MHS AWARD: Mind Recovery College	Hardy, D	2016	Australia	✓	✓	✓	✓
The Recovery College Course Guide Spring 2016	The Recovery College	2016	UK		✓		✓



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Title	Author(s)	Year	Place Published	Student group and engagement	Evaluation outcomes	Models of intervention	Service design and delivery
The Recovery College: Cultivating mindfulness to improve CALD mental health consumers' carers' wellbeing	Stott, S; Saad, H	2017	Australia				✓
The route to employment: the role of mental health Recovery Colleges	Taggart, H; Kempton, J	2015	UK	✓	✓	✓	✓
The Transformatory Power of a Recovery College	Repper, J	2013	UK	✓	✓	✓	✓
The value of a peer operated service	Social Ventures Australia	2018	Australia	✓	✓	✓	✓
Towards Recovery - Hope, Innovation and Co-Design	Psychiatric Disability Services of Victoria	2016	Australia	✓		✓	✓
Why a Recovery College?	Perkins, R	2012	UK			✓	✓
Working in Partnership: South Eastern Sydney Recovery College	Trindall, M; Stott, S	2017	Australia	✓		✓	
			Total references to themes	29	28	23	42

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### 4.1.4. Strength of evidence

Peer-reviewed articles were assessed for strength of evidence in line with the NHMRC guidelines detailed in *Section 3.2*. No systematic reviews or randomised controlled trials were identified within the peer-reviewed literature. One study (Dunn et al. 2008) utilised a quasi-experimental methodology, allocating participants to either a recovery education program or control group to assess differences in health, mental health, subjective and role functioning outcomes. Whilst the study employed a form of recovery education practice, it was not consistent with key Recovery College characteristics.

The majority of studies were classified as either cohort studies without concurrent controls, case series with pre and post-test outcome measures or background information/expert opinion. It was a common theme throughout the literature for authors to call for more advanced scientific enquiry in relation to evaluating Recovery Colleges, including randomised controlled trials (Mcgregor & Hoban 2015, Meddings et al. 2015, Bourne et al. 2017). However, as identified by Meddings et al. (2015), the ability to fix the very process of co-production within an RCT is highly problematic and works against the co-production philosophy of a Recovery College model.

Thus, the authors recognise that evidence concerning the effectiveness of Recovery Colleges is in a maturing state, and that substantial challenges exist to conducting randomised controlled trials in an environment which calls for considerable flexibility and responsiveness to the needs of students in the development and delivery of a Recovery College model.

The following sections detail findings from the literature review search and analysis, drawing upon the evidence gathered through peer-reviewed and grey literature searches. Priority has been given to peer-reviewed literature, and where required, grey literature is drawn upon to highlight and add service delivery context to available peer-reviewed evidence.

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### 4.2. Key characteristics of a Recovery College

Before discussing the key themes uncovered from the literature search and analysis, a brief overview of key aspects of Recovery College models is presented to contextually inform the discussion of findings. This will include an overview of:

- Key fidelity criteria that describe what a Recovery College model is
- The educational as opposed to therapeutic mode of service delivery
- The use of Individual Learning Plans (ILPs).

#### 4.2.1. Key fidelity criteria

Advocates of the Recovery College model have developed fidelity criteria that describe what a Recovery College is and the philosophy adopted in service delivery (Meddings et al. 2015). A Recovery College is:

- **Based on educational principles:** it has a clear structure for lesson plans, courses and terms. There is a strong educational focus in all documentation and language. Students have “Individual Learning Plans”. Tutors or learning and development advisors help students with course selection. Curriculum is overseen by a Quality/Academic Board
- **Employs co-production:** everything (e.g. courses, materials, location design) is co-produced with students, with co-facilitation and co-learning a frequent occurrence
- **Strengths-based:** students and staff are not viewed with deficit in mind, e.g. students are not viewed for what is wrong with them, but for the positive qualities they bring to the Recovery College
- **Based at a physical location:** colleges have a physical location in the community that either stands alone or is co-located with an existing service. In both the UK and Australia, some are co-located alongside mental health services but most are in the community alongside other agencies, shops, and community venues. Most are designed to be like other educational colleges, with student cafeterias, computer study spaces and libraries for research
- **Person-centred:** the student chooses the courses they are interested in attending; they are not referral-based. There is no requirement for diagnosis or risk assessment
- **Progressive:** students work towards goals beyond the college and graduation, and are encouraged to take ownership of their own Individual Learning Plan (ILP) which details their personal educational goals
- **Community-facing:** there is active engagement with local agencies, organisations and community colleges to co-produce relevant courses and facilitate pathways into valued roles, relationships and activities
- **Inclusive:** Recovery Colleges are for everyone – people with mental health challenges (whether using specialist services, their GP, or no services), family, mental health service staff, and people from other social sector agencies. Students of all abilities, cultures, ages and experiences are welcomed (Ashton, 2017, McGregor et al. 2014, Meddings et al. 2014).

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### 4.2.2. Educational model

The Recovery College literature commonly contrasted educational and therapeutic approaches to recovery. This contrast is illustrated in *Table 4-3* (Jay et al. 2017, Perkins et al. 2014), and forms the principle philosophical underpinning of what a Recovery College model espouses to be, i.e. an educational rather than therapeutic service.

**Table 4-3: Therapeutic and educational approaches**

Therapeutic approach	Educational approach
<ul style="list-style-type: none"><li>• Focuses on problems, deficits and dysfunctions</li><li>• Strays beyond formal therapy sessions and becomes the overarching paradigm</li><li>• Transforms all activities into therapies (e.g. gardening therapy, work therapy)</li><li>• Defines problems, with the type of therapy chosen by the 'professional expert'</li><li>• Maintains power imbalances and reinforces the belief that all expertise lies with the professional</li><li>• Is often crisis driven</li><li>• Encourages the identity of a 'good patient' who is compliant and adherent</li></ul>	<ul style="list-style-type: none"><li>• Helps people recognise and make use of their talents and resources</li><li>• Assists people in exploring their possibilities and developing their skills</li><li>• Supports people to achieve their dreams and ambitions in the context of their actual life experience</li><li>• Has staff who become coaches who help people find their own solutions</li><li>• Lets students choose their own courses, work out ways of making sense of (and finding meaning in) what has happened and become experts in managing their own lives</li></ul>

### 4.2.3. Individual Learning Plans

ILPs are plans created with a tutor or peer learning support worker at the Recovery College to help students identify specific learning goals for the term. The development of ILPs also represents an opportunity to learn more about which courses will meet a student's needs and to discuss any learning needs they may have.

Some examples of areas covered in an ILP include:

- Hopes, ambitions and goals
- Previous experiences
- Learning support needs
- Strengths
- Things the student would like to work on or improve
- Courses chosen (Repper 2013).

At the end of term, students are invited to attend a review meeting to reflect on personal progress if desired.

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The key fidelity criteria, educational heuristic and use of ILPs can be considered the key defining features of a Recovery College. However, it is recognised that some colleges may develop and evolve these concepts organically.

The following section presents findings from the literature review, organised by the Commission's specified areas of inquiry, including:

- Student group and engagement
- Service design and delivery
- Models of intervention
- Evaluation.

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### 4.3. Student group and engagement

This section describes the:

- Characteristics of students accessing Recovery Colleges
- The level of engagement students have with Recovery Colleges
- The barriers to and enablers of accessing Recovery Colleges.

#### 4.3.1. Student characteristics

##### Socio-demographic profile of students

Across the peer-reviewed and grey literature there were consistencies between Recovery College student characteristics. Whilst in general Recovery Colleges are built upon principles of inclusivity, it was common for eligibility for course enrolment to be restricted to those over the age of 18 (McGregor et al. 2014, McCaig et al. 2014). Even where papers did not specify age restrictions, students were generally 18 and over and fell primarily between the ages of 25 and 55 years (Chung et al. 2016, Meddings et al. 2015, Meddings et al. 2014, Anfossi 2017). However, co-production of a version of a Recovery College for younger adults (16 to 25 years) called The Discovery College has been developed in the UK (Burhouse et al. 2015).

A 2017 survey of 39 Recovery Colleges in the United Kingdom found that the mean age of all students was 42.4 years, with a range between 17.8 and 74.3 years (Anfossi 2017). Seven Recovery Colleges in the survey reported delivering courses to those as young as 16 years old, and two Recovery Colleges delivered courses for those over 17 years old (Anfossi 2017).

It was **common for females** to access Recovery Colleges in greater proportions than males (McGregor et al. 2014, Bourne et al. 2017, Chung et al. 2016). For example, the Mayo Recovery College in Ireland reported that in its first year that most students were women. However, the following year a greater gender balance was reported (McDonagh 2014). Unfortunately, no studies investigated the propensity for a Recovery College model to increase access for males, an area which may be of interest in future research and evaluation given low help-seeking rates by men in response to mental illness (Ellis et al. 2015).

There is limited literature about the **cultural identities** of Recovery College students. People from Culturally and Linguistically Diverse (CALD) backgrounds have lower levels of access to mental health care and support in the wider community (Guo et al. 2015). The South Eastern Sydney Recovery College (SESRC) reported it delivers courses in nine languages, with a number of CALD-specific courses included in the curriculum (Trindall & Stott 2017). Of their 1078 students, 28 identified as Aboriginal and Torres Strait Islander (with half of these being Elders in the community) (Trindall & Stott 2017). As with CALD populations, there has been little research into how the mental health system meets the needs of Aboriginal and Torres Strait Islander people (Schrank & Amering 2017). No studies report on the delivery of courses to these populations, however it is crucial that Recovery Colleges provide a culturally secure and culturally competent environment for vulnerable populations (McGough et al. 2018).

**Income and employment information** relating to Recovery College student cohorts was not routinely reported, however inclusion criteria and fee structures of colleges aimed to increase access to those

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unemployed or in low or no income circumstances, and there was no requirement to have prior academic qualifications to enrol (Meddings et al. 2015, McGregor et al. 2014). A study that developed two 'pop up' Recovery Colleges in Gloucestershire and Herefordshire found that the educational range of the students was very wide, with several students having literacy issues or specific learning difficulties (Burhouse et al. 2015). There were reports of high levels of peer support, both educationally and emotionally, which was useful given that some students had no formal education qualifications, whilst others had doctorate or professional qualifications (Burhouse et al. 2015).

By nature of their **inclusive practices**, Recovery Colleges could be accessed by those experiencing mental illness and their family and carers, as well as service provider and service sector staff which in some cases included clinical mental health professionals and clinical students working toward tertiary degrees in the mental health field (Dunn et al. 2016, Windsor et al. 2017, K H Gill 2014). One exception to this rule was a Recovery College that had been setup within a secure, forensic mental health setting (Frayn et al. 2016), where access was restricted to residents within the facility.

The 2017 survey of 39 Recovery Colleges in the UK found that:

- 51% of colleges registered relatives, carers or supporters to attend courses
- 46% registered National Health Service (NHS) staff
- 33% registered staff from other organisations (Anfossi 2017).

Reported benefits to offering enrolment to clinical students and staff included flattening the hierarchy of power by having health workers and psychologists sit amongst students and creating an environment where everyone is on a level playing field (Windsor et al. 2017).

**Accessibility of services** was also of prime concern to the delivery of a Recovery College model. The Central and North West London Recovery College reported that 7% of their students had physical or mobility difficulties (Taggart & Kempton 2015). The provision of accessible course materials should be considered, with alternative formats produced on request e.g. in Braille, in large print, on a coloured background, or in a particular font (The Recovery College Camden and Islington 2016). One key example provided by Zucchelli & Skinner (2013) describes a deaf student who wished to access the Recovery College. The college engaged an interpreter to attend the course with the student, which resulted in the interpreter also deriving benefit from the course content.

### Mental health, AOD and homelessness

The **mental health status** of those accessing Recovery Colleges was reported across a number of studies and provides an indication of the level of acuity of those accessing these services. Bourne et al. (2017) reported that 90% of their 463 Recovery College student sample fell into either the moderate to severe non-psychosis cluster of the Health of the Nation Outcome Scale (HoNOS), whilst 5% were classified within the psychosis cluster. Elsewhere, Rinaldi et al. (2012) reported that 44% of students at the South West London Recovery College had a diagnosis of schizophrenia and 13% had a diagnosis of bipolar disorder, while Meddings et al. (2015) reported 62% of students accessing the Sussex Recovery College had anxiety or depression, 37% psychosis and 1% dementia. One article from the grey literature reported that students had, on average, been using mental health services for six years, and 45% had a diagnosis of psychosis (Taggart & Kempton 2015).

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It should be noted that enrolment in existing Recovery Colleges is not dependent on having a mental health diagnosis or disclosing a diagnosis, though it was recognised that during courses many students felt comfortable to disclose such information in the Recovery College environment (McGregor et al. 2014). In all cases, those with lived experience of a mental health issue were the primary user-group of Recovery Colleges abroad and within Australia, but there is evident diversity in the make-up of mental health diagnosis and access to Recovery College services.

In Australia, the peer-operated service run by Flourish Australia reports that the majority of the students who access their service have a severe and persistent mental health issue (Social Ventures Australia 2017). Mind Recovery College reported that 27 of the 34 participants at the three *Medications Coproduction Workshops* had personally taken psychotropic medications (participants included health professionals, carers and consumers) (Hardy 2016a).

Recovery Colleges are typically situated in the mental health, rather than the addictions sector (Ashton 2017). Currently, no studies have reported on student use or abuse of **alcohol and or other drugs**, or incidence of **co-occurring mental health and AOD issues**. However, reports could occur in the future, as the South Eastern Sydney Recovery College (SESRC) have introduced a new project for the period of June 2017 to June 2018 to include people 18 years of age and over who use drug and alcohol services and live in the South Eastern Sydney Local Health District catchment (South Eastern Sydney Recovery College 2018).

In one service delivery model in Canada, developed specifically as a Recovery College for those experiencing **housing instability** and mental health issues, students were comprised of '48.2% living in shelters, hostels, or rooming houses, 24.4% lived in supportive or subsidized housing, 10.1% lived in market-rent housing, and 8.3% lived in transitional housing' (Chung et al. 2016, p. 853). In 2012, a Recovery College for homeless people was launched as an experiment by St Mungo's charity in Southwark, London. At the start of the second term, 395 students were enrolled over 60 courses, with the most popular courses focusing on raising self-confidence and developing self-esteem (Coughlan 2013). St Mungo's have Recovery College hubs in London and Bristol, and plan to expand their hubs to reach more people (St Mungo's Registered Charity 2018).

### 4.3.2. Student engagement

The majority of existing Recovery College services record an **attendance rate** of between 60 and 70%, a rate which is consistent with other adult learning facilities and service delivery models (Meddings et al. 2015, Meddings et al. 2014, Kaminskiy & Moore 2015, Rinaldi & Wybourn 2011, Repper n.d.). A newspaper article reporting on Recovery Colleges stated that those who attended at least 70% of sessions showed a marked reduction in their use of other mental health services (Camus & Goodchild 2015). In the Recovery College being delivered within a secure-setting, 35% of the facility's residents had completed at least one workshop (Frayn et al. 2016).

The **average number of courses** students completed ranged from 2.6 (Rinaldi & Wybourn 2011) to 2.9 (Perkins et al. 2017), with one student completing a total of 10 courses at a Recovery College in England (Perkins et al. 2017). The 2017 survey of 39 Recovery Colleges in the UK found that the average number of sessions attended by students is 3.2 sessions (Anfossi 2017). Secker & Wilson (2014) reported that students at the Mid Essex Recovery College attended on average 5.3 sessions.

The Mind Recovery College reported that the average class size of nine students was steadily increasing and **waiting lists** were now needed, as there are maximum class sizes that are considered appropriate



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depending on the topic (Hardy 2016a). Moreover, the number of student places was also steadily increasing from 399 places in 2014 to 630 places in 2015. In contrast, the Mayo Recovery College in Ireland report that they do not have waiting lists and in principle do not refuse students, because it can be challenging for people to take the first step to enrol (McDonagh 2014).

A key factor affecting attendance and engagement with Recovery Colleges was found to be the **socio-demographic and health status** of enrolled students, though only one article reported on such impacts. Rinaldi & Wybourn (2011) found that those diagnosed with substance misuse were less likely to complete 70% or more of the courses they had enrolled in when compared with other diagnostic groups (e.g. mental health related diagnoses). This suggests that in delivering a Recovery College model intent on service delivery for those experiencing AOD issues, attention should be directed towards keeping this cohort engaged in the college. Rinaldi & Wybourn (2011) also reported that those aged between 26 and 40 years of age were less likely to complete 70% or more of the courses they had enrolled in when compared with other age groups, whilst no differences in course completion were observed between males and females.

An evaluation of the Greenwich College in 2016 found that **primary motivations** for attending courses included an opportunity to learn a new skill (25% of students) and to learn something new (21% of students) (Wels 2016). The report found that involvement with the college reduced isolation, as 10% of students reported wanting to get out of the house and 13 per cent wanting to make new friends. Over 80% of graduates of the college wanted to stay involved and help the college grow, leading to the development of a community of volunteers.

The willingness of peers to interact with one another and reciprocate support demonstrates the power of peer support as a tool in Recovery Colleges. Having peers who have endured similar difficulties provides a safe space for students to engage with the course. The Hervey Bay peer-operated service run by Flourish Australia has proactive peer workers and volunteers who actively check in (generally by phone) if someone has not been seen at the centre for a while (Social Ventures Australia 2017).

### 4.3.3. Barriers to and enablers of student engagement

#### Practical barriers

Several barriers to access and course completion for students have been identified in the literature. A common theme in many papers concerned the **distance required to travel** to a Recovery College location, and the physical location or venue in which the Recovery College was being delivered. In a survey of 16 UK Recovery College students who had missed classes, the main barrier identified was travel time, with an average time in transit of 45 minutes each way (Dunn et al. 2016). The same cohort raised concerns with the venue in which the college was being delivered, citing that courses being delivered in rooms that had no windows facing external areas caused concern, and the requirement to use a buzzer to enter the building signified an unwelcoming environment (Dunn et al. 2016).

Similar barriers were identified by Kelly et al. (2017) and Secker (2014), where students raised concerns over travel times and felt that classes should be delivered in discrete locations that are separate from other services. The 2016 evaluation of the Greenwich Recovery College found that some people had difficulty paying for **transport, petrol and parking** which made the decision to attend classes harder (Wels 2016). A novel way to address these accessibility issues is described in the Case Study 1 below.

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Accessibility issues also extend to **opening hours** of Recovery Colleges, with working cohorts finding it difficult to work and attend courses due to time clashes (Kelly et al. 2017, Machin & Repper 2013) and others who require childcare services (Burhouse et al. 2015). Recently, the University of Bradford held a workshop to discuss the development of an innovative technological solution to enable students to participate in sessions from home. The location and delivery of Recovery Colleges is further detailed in *Section 4.4.1*.

As discussed in *Section 4.3.1*, some people experience **educational barriers** that require literacy support or other adjustments to course delivery (Burhouse et al. 2015). Other barriers to attending classes were **psychological**, where people believed that they were not good enough to go to 'college' (Burhouse et al. 2015). An evaluation of the South Essex Recovery College found that some respondents reported feeling anxious about attending the college, particularly about joining the group, fitting in, and feeling out of place (Kaminskiy & Moore 2015).

Outside of the community mental health setting, challenges for Recovery College service delivery within secure services are magnified. Frayn et al. (2016) detail that the very nature of secure settings sits in contradiction with the nature of Recovery College principles. In a secure setting, those attending courses are also subject to being contained and viewed as a potential risk to be mitigated at all times. This presented significant challenges in exploring recovery within this unique context (Frayn et al. 2016).

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### Case Study 1: Pop up Recovery College

The study that evaluated two ‘**pop up**’ **Recovery Colleges** was designed to be suitable for the largely rural counties of Gloucestershire and Herefordshire (Burhouse et al. 2015). The study designed temporary pop up Recovery Colleges that used local educational resources such as local colleges and adult education centres that would be better suited for the rural geographical area, rather than a permanent base. In designing the pop up Recovery Colleges in consultation with South West London Recovery College, the researchers realised that not having a permanent base would mean that students would miss out on informal support. As such the pop up Recovery Colleges implemented:

- Five ‘taster days’ where people came along to see if the course was for them
- A café style space for socialising over lunch as part of the course
- The use of volunteers for travel and classroom support
- The provision of self-management support workbooks at the end of the course for those who wanted to continue the practice
- The option for three personal coaching sessions at the end of the course to help provide ongoing motivation for change
- A “Recovery Space Day” that followed course completion to allow students to have further sessions on practical and creative skills.

A graduation event was held several months later to offer people a chance to celebrate their successes. There was limited analysis on the pop up model and the use of local educational resources in this study, however the evaluation found that the venue and atmosphere of the Recovery College was important, and for a rural cohort, time and costs for people to socialise together should be factored in.

### Trauma, distress and illness

Some authors found that at times courses may cause **distress or re-ignite traumatic experiences** for some students (Hall et al. 2016, Dunn et al. 2016, Zabel et al. 2016). At the Mind Recovery College, some students reported that it was challenging to handle the distress of others during courses, and that it sometimes triggered past pain of their own (Hall et al. 2016). Whilst the experience did not deter these students from ongoing attendance, it is a factor to consider in managing group dynamics within classes (Dunn et al. 2016, Duff 2016, Zabel et al. 2016).

In a focus group study with ‘Recovery Academy’ students, Zabel et al. (2016) found that an individual’s stage of recovery may be a potential barrier to course attendance. This sentiment was echoed by Dunn et al. (2016) with students citing poor psychological wellbeing potentially affecting motivation to attend,

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creating feelings of anxiousness and not knowing what to expect during the course. Physical illness was also cited as a barrier to attendance (Harper & McKeown 2017).

### Staff related barriers

In addition to barriers affecting attendance and course enrolment by students, barriers existed that prevent staff from delivering courses to a **high standard of quality** and in congruence with Recovery College fidelity criteria. Gill (2014) found that in development of a Recovery College in South Eastern Sydney, the level of support and training required for staff involved in course co-facilitation was largely underestimated, particularly in relation to adopting a co-production approach to Recovery College delivery, and embedding recovery into the curricula being developed (Kelly et al. 2017).

Elsewhere, **lack of knowledge** and unfamiliarity with IT systems, including navigating new IT systems, ensuring rooms were not double booked for classes, and some instances where staff were called upon to deliver courses they had little involvement in developing. It was found that practitioner trainers found it difficult to balance their duties with the Recovery College with their clinical duties, highlighting the need to be mindful of staff workload and allocation (Skinner & Bailey 2015).

It is important to note that **peer facilitators**, who themselves have experience of mental health problems, were seen as an important component of Recovery Colleges. For example, the evaluation of the South Essex Recovery College found that 93% of students said that it was very important to have a facilitator with lived experience of mental illness (Kaminskiy & Moore 2015). Peer support provides a social connection and is valued by students as it provides opportunities for building social networks (Ashton 2017).

### Overcoming barriers

In a study of barriers to Recovery College attendance, Dunn et al. (2016) found that strategies to overcome barriers were not dissimilar from strategies used in other educational institutions. Study participants suggested a number of potential strategies including:

- Sending text reminders on the day before or on the day of a student's course
- Discussing attendance needs during the development of ILPs
- Providing students with an indication of class size
- Offering students travel advice with maps and public transport options
- Following up students who miss classes by tutors
- Providing clear course information in the prospectus, and effective communication between staff and students (Dunn et al. 2016).

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### 4.4. Service design and delivery

This section will cover:

- The ways in which Recovery Colleges develop over time
- The main characteristics of existing Recovery Colleges
- The human resources that are in place to deliver existing Recovery College services.

#### 4.4.1. Service development

##### Development over time

Most Recovery Colleges developed organically, **evolving in response to co-production** practices. Some articles described plans of how the first few years of a Recovery College might look as it develops through co-production. A key example of service development in Australia is illustrated in Case Study 2.

### Case Study 2: Mind Australia

The Mind Australia Recovery College in Victoria specified a series of approaches to service development over a period of three years, including:

- Developing the concept for the model
- Developing a business case for the development and implementation phase
- Developing a plan for service delivery at two pilot sites
- Testing and development of course content with existing Mind Australia clients
- Working toward operational sustainability (investigating funding and partnership options) (Mind Australia 2012).

Since beginning in 2013, the Mind Recovery College model has expanded and now delivers “over 50 different courses across seven campuses in Victoria and South Australia” (Hardy 2016, p. 8).

Once established, it was important to ensure that course content is continually monitored and evaluated through the co-production process (Meddings et al. 2015). Indeed, the experience overseas is that courses are continually evolving (Zabel et al. 2016, Perkins et al. 2012, McGregor et al. 2014), and evaluative processes that include review by a quality assurance panel comprised of staff and students are encouraged (Zucchelli & Skinner 2013).

Whilst many Recovery Colleges experience significant growth over the first few years of existence, not all have experienced such success. The South Essex Recovery College is one example where significant challenges were met and growth remained stagnant over the two year implementation phase.

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Kaminskiy & Moore (2015) detail that a lack of strong strategic vision, an absence of partnerships with existing Recovery College networks and instability in Recovery College management in the first few years significantly hampered progress toward a sustainable model (Kaminskiy & Moore 2015). According to the 2017 survey of 39 Recovery Colleges in the UK, most reported having referred to Implementing Recovery Organisational Change (ImROC) briefing papers to inform their development (Anfossi 2017).

### Partnerships

**Strong partnerships** were considered vital in the development phase of a Recovery College and contributed to ongoing sustainability within the mental health system (Hardy 2016a, Zucchelli & Skinner 2013). Whilst distinctly an educational institution, the Central North West London Recovery College was firmly embedded within the broader organisational structure of local mental health services (Zucchelli & Skinner 2013). The Mind Recovery College reported that the Recovery College model made it easy to partner with a variety of organisations, having been developed by a community mental health organisation (Hardy 2016a). For Mind Recovery Colleges in Australia, partnership discussions are ongoing with several local health and social services, including Victoria Police and various education providers.

The 2017 survey of 39 Recovery Colleges in the UK found that 85% of Recovery Colleges worked with various partner organisations to co-produce and co-facilitate courses (Anfossi 2017). Partner organisations included universities, health care providers, third sector organisations, emergency services and social care providers. Moreover, 56% of Recovery Colleges reported having benefited from visiting other Recovery Colleges, and 72% were interested in joining a network that linked them to other colleges (see Communities of Practice below).

The Hastings Recovery College formed partnerships with the voluntary sector to promote and collaborate with in delivering the Recovery College service (Meddings et al. 2014), whilst a Recovery College situated within a Scottish University formed partnerships with local recovery networks, including AOD services, though the authors did not stipulate what these partnerships involved (McCaig et al. 2014). The Recovery College does deliver a 'Opening Conversations about Drugs and Alcohol' course, however it is not stated whether this was developed in collaboration with the AOD service. Many of these partnerships informed curriculum development and provided much needed visibility of the Recovery College to the community and people accessing existing services.

### Communities of Practice

There is an **International Recovery College Community of Practice** (IRC CoP) which is a collaboration of colleges including Mind Recovery Australia, St Michael's STAR Learning Centre in Toronto, and other members from Canada, UK, USA, Ireland, Italy, France, Japan and Uganda (Hardy 2016a). The IRC CoP was created to exchange practice, engage in joint activities, as well as collaborate on research opportunities.

Other partnerships are established on more practical grounds, for example, partnerships with local community colleges already providing adult education models mean that mainstream venues can be used for Recovery College course delivery (Jennings et al. 2017, Watts et al. 2014). Mind Australia

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(2012) set out clear plans for partnerships in the Recovery College development phase, including partnerships with:

- Existing organisations whose consumers may be interested in accessing the Recovery College
- Peak bodies and other representative organisations who may have an interest in funding aspects of the Recovery College
- Research institutions willing to assist in research and evaluation of the Recovery College
- Other educational institutions who may be interested in developing pathways from the Recovery College into further education for students (Mind Australia 2012).

Partnerships with education organisations were identified as particularly important, as they go beyond thinking about the sustainability of the Recovery College, to clearly articulating how students who graduate from the Recovery College can progress into further study and employment, enhancing recovery opportunities (Hall et al. 2016).

### Governance

The structures put in place for governance varied across Recovery Colleges. In the Greater Manchester West Recovery College a steering group was established in the early phases comprising of ‘service-users, health professionals, managers, clinicians and family members/carers’ (Zabel et al. 2016, p. 163). In the Canadian Recovery College providing courses for those with mental illness and housing instability, a community advisory board was established, which had representation from those with a lived experience of mental illness and housing instability. This board served to inform the development of the programs being delivered (Chung et al. 2016).

At Mind Australia, a college director with lived experience of mental illness and recovery was appointed, and placed in charge of the operational aspects of the college (Mind Australia 2012). The Governance Committee for the college comprises ten members, with two members who have first-hand experience of mental illness (Hardy 2016a). Moreover, each campus has a Local Working Group which assists and advises on all aspects of campus operation. The group comprises three to four consumers, two carers, two local staff, the Campus Manager and a Learning and Development Consultant.

Whilst positive and negative aspects of existing governance structures was not discussed within the literature, a number of common characteristics of governance structures were identified, along with attributes of governance positions that set up a Recovery College for success. These commonalities included:

- **Presence of lived experience (Gill 2014):** Any governance arrangement should include those with a lived experience of mental illness. This experience can be drawn upon to inform development of courses, provide quality assurance of course material, and to ensure students are appropriately represented at board level
- **Leadership that can ‘carry the culture’ (Perkins et al. 2018):** Ensuring that the Recovery College is led by an individual with either mental health sector experience or lived experience (or both) who can champion the Recovery College model was identified as important
- **Establishment of a Quality Assurance/Academic Board (Meddings et al. 2015):** Quality assurance should be overseen by governance comprising all stakeholders in the Recovery



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College, including 'college staff, both peer trainers and mental health professionals, managers, senior professionals and student representatives' (p. 216). This board will generally oversee curriculum design, approval of new courses and ensuring co-production is adhered to

- **Training and steering group (Mcgregor & Hoban 2015):** Drawn upon to ensure training of new peer facilitators/staff is provided and updated where required. This may comprise individuals with expertise or a background in adult learning or education.

### Co-production

Co-production is one of the key fidelity criteria when assessing adherence to the Recovery College model of service delivery (see *Section 4.2.1*). Existing Recovery Colleges utilise similar approaches, with co-production at the heart of all decisions related to the development of course materials, policies and procedures, through to ongoing review and reshaping of service delivery (Anfossi 2017). The Mind Recovery College in Australia even used the co-production process to design the College space, with a group of consumers, carers, staff and a domestic interior designer (Hardy 2016a).

Co-production can be summarised under three main sub-themes (Anfossi 2017):

- **Equality:** involves breaking down the barriers between staff and students, giving everyone an opportunity to contribute, making decisions together and sharing responsibilities
- **Lived experience & expertise:** working together in the Recovery College
- **Course planning:** courses are co-designed, co-facilitated, co-delivered and students are involved in the evaluation and review of courses.

Challenges of co-production were discussed in detail at the Recovery Colleges International Community of Practice Proceedings in 2015 (Mcgregor & Hoban 2015), and provide a useful overview of considerations when implementing and undertaking a co-production approach in relation to Recovery College development. These considerations are illustrated below (Mcgregor & Hoban 2015).

In order to see such an approach come to fruition, there needs to be significant buy-in from the organisation staff and wider community. In some instances, **co-production training** is developed for boards and executive teams, management and front line staff to ensure these practices become embedded (Perkins & Slade 2012, Kelly et al. 2017). Without such training, some Recovery Colleges have observed clinical staff reverting to dominating the design process, rather than embracing the co-production ethos (Zucchelli & Skinner 2013).



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### Considerations for co-production

**Maintaining** respect, equality and trusting relationships

**Recognising** the creative nature and value of co-production

**Understanding** that co-production feels enjoyable, refreshing and collegiate but also can be exhausting

**The need** for bringing together peer and professional expertise, and understanding how these work together to bring about change

Providing **appropriate training** to contributors in team work, questioning, problem solving, framing and listening

**Willingness to learn** – ‘speak less and listen more’

**Managing control and power** – containing rhetoric, surrendering power, working toward joint decision making/responsibility, constructing shared language and building confidence of others

Being aware of **assumptions** including pre-existing ideas around collaboration and sharing

**Openness to challenges** – Managing conflict and provocation, challenging at appropriate times, understanding comfort zones and boundaries

**Setting the scene** – developing an understanding of design principles, rules of engagement, building relationships, developing expectations

**Compensation** – Advocacy for equal pay in co-production, consideration of fair compensation for peer work alongside professional work

**Practicing** feedback and reflection on the co-production process (McGregor & Hoban, 2015)

Hardy (2016b) explains that co-production aims to encourage innovation and thus hard and fast rules about what constitutes co-production could stifle innovation. Instead, going ‘deeper’ within the idea of layers of co-production (see *Table 4-4*) could facilitate innovation and provide an environment where a number of experts (both professionals and those with lived experience) are involved. For example, The Mind Recovery College reports that the use of a narrative technique such as ‘anecdote circles’ in co-production workshops have been very effective (Psychiatric Disability Services of Victoria 2016). Anecdote circles encourage participants to share short stories focused on one or two targeted questions. The technique allows content to be captured and grouped into themes that guide course design. This process has seen new teachers emerge from these workshops (Psychiatric Disability Services of Victoria 2016).

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**Table 4-4: Layers of co-production (Hardy, 2016)**

Layers of co-production	Design and delivery		Expertise involved
<b>Layer 0</b> Can be seen as traditional consultation	Consult with segmented stakeholder groups, ideas processed later	Professionals deliver initiatives	Mental health professionals
<b>Layer 1</b> Can be thought of as 'consultation plus'	Consult with segmented stakeholder groups, ideas processed later	Professionals deliver initiatives, with some input from clients e.g. "guest speakers"	Mental health professionals and people with lived experience
<b>Layer 2</b> Sees the growth of partnerships between consumers and providers, in which each can play an equal role in design and delivery	Mix of stakeholder, some processing done in the room	Professionals and clients work together, with clearly defined areas of expertise	Mental health professionals and people with lived experience
<b>Layer 3</b> Sees the blurring of lines between professional and consumers, allowing for new ways of communicating and producing new ideas	Create new discursive spaces, not always clear who has which role	Expertise not tied to specific individuals, people wearing many hats at once	Actively seek any relevant experience, including learning and development, and develop skills where needed

### Location design and set-up

As discussed earlier (Section 4.3.3), the location of a Recovery College can either facilitate or be a barrier to accessing courses. There are a **number of modalities** that a Recovery College can exist as: a physical building, satellite bases, or through a hub and spoke model (see Table 4-5).

According to a study of the 39 Recovery Colleges in the UK, 64% of Recovery Colleges have a physical base, and 92% of colleges use a variety of venues (either in addition to or instead of a main base). Some Recovery Colleges are based within health organisations, whilst others can be in education facilities (Smith-Merry et al. 2016). The benefit of having a base is that there is a tangible representation of commitment to the Recovery College model (Perkins et al. 2012).

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**Table 4-5: Recovery College location models**

Recovery College location models	Advantages	Limitations
<b>Physical building</b> A college housed in one building which may provide classrooms, a library and a space for administrators	<ul style="list-style-type: none"> <li>• Tangible representation of commitment to the Recovery College model</li> <li>• Provides a space for students to meet informally and expand social networks</li> </ul>	<ul style="list-style-type: none"> <li>• Needs to take into consideration transportation needs of the students</li> <li>• May not meet the needs of a population due to potential geographical and financial constraints, as well as lack of adequate infrastructure in the area</li> </ul>
<b>Satellite bases</b> A college which would have one physical base, but courses would also be offered at satellite bases	<ul style="list-style-type: none"> <li>• May also provide classrooms, a library and a space for administrators</li> <li>• A number of different venues could be used, e.g. community colleges, mental health services, community halls etc.</li> <li>• Greater reach for regional and/or rural population groups</li> </ul>	<ul style="list-style-type: none"> <li>• Relies on students being able to physically access the main building and satellite bases</li> <li>• Requires regular promotion of courses run at other sites</li> </ul>
<b>Hub and spoke model</b> A central point of contact (potentially web-based) with regional spokes that would provide local learning provision	<ul style="list-style-type: none"> <li>• The innovative technological solution of a virtual hub would provide empowerment and learning opportunities for students to access from home</li> <li>• Potential for course to reach a wider population not limited to geographical boundaries</li> </ul>	<ul style="list-style-type: none"> <li>• Requires students to have access to a computer and the internet</li> <li>• Reduces the opportunity for students to meet informally and create social networks</li> </ul>

An accessible non-threatening hub with classrooms, administrators and a library could improve student participation as they feel part of something that is formally recognised (Anfossi 2017). Libraries within Recovery Colleges can provide computers with free internet access and collections of self-help books, inspirational and recovery-focused books and books on living with different health issues including mental illness (The Recovery College Camden and Islington 2016). Moreover, having a student card was also reported to be important, as the status of a student allows for people to have a sense of belonging (Health Service Executive & Advancing Recovery in Ireland 2016, Coughlan 2013).

In London, the Greenwich Recovery College relocated to a new site which hosts a café. This has allowed for the college to develop into a local mental health and wellbeing hub and also provides an informal communal space for staff and students (Morgan 2017). In Hervey Bay, Queensland, the peer-operated service run by Flourish Australia has a resource centre that is located in a 'normal' house and was found to be inviting as it also provides an informal space for people to meet (Social Ventures Australia 2017). Flourish Australia also run a rest and recovery three-bedroom house where people can take time out from their existing living arrangements to invest in self-care practices (Social Ventures Australia 2017).

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Meanwhile, the South Eastern Sydney Recovery College deliver courses at a number of venues including community colleges, a migrant resource centre and mental health services (Nunley & Stott 2016).

### 4.4.2. Service characteristics

#### Curricula/prospectus content

Information regarding curricula and prospectus content was abundant within the peer-reviewed and grey literature. Several colleges grouped course content into distinct categories, typically:

- **Understanding mental health issues and treatment options:** understanding anxiety, understanding the Mental Health Act
- **Rebuilding life with mental health challenges:** mindfulness, getting into study
- **Life skills:** managing money, problem solving skills, making and keeping connections
- **Family and friends:** supporting recovery and looking after yourself as a carer
- **Capacity building amongst the peer workforce:** the strengths model in practice, skills for educators (Ashton 2017).

Through documentation of Recovery College curricula, the Mental Health Community Coalition ACT Inc. (2017) identified four groupings that would support people with mental illness:

- **Health matters:** dealing with aspects of mental illness such as understanding and managing living with mental illness
- **Life matters:** safely navigating through the complexities of living in a community and supporting our relationships
- **Caring matters:** supporting carers through learning, services and connection with each other
- **Work matters:** how people can find ways back to education and support to work.

It is important to understand that, dependent upon the student demographic, location of the Recovery College, and co-production process, course content may vary considerably (Skinner & Bailey 2015).

For the Canadian Recovery College delivering courses with those experiencing unstable housing and mental illness, course content was tailored specifically to issues around housing and the operational aspects of maintaining accommodation (Chung et al. 2016). In the secure setting, Recovery College courses taught cooking and food hygiene (Frayn et al. 2016), whilst the SESRC also offer nationally-accredited courses such as Foundation Skills and Certificate II Business.

Evidence of co-produced Aboriginal and Torres Strait Islander courses is scarce, with the only available courses specific to this population being Mental Health First Aid and cultural competency courses (One Door Mental Health, 2018)

Further, the maturity of a service will often determine the depth and breadth of courses offered. In many cases, established Recovery Colleges have developed niche and specific course content, for example, the Brighton Recovery College had developed courses for members of the Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) community (Meddings et al. 2014). It was also highlighted

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that when developing course content, attention should be paid to what already exists within the service ecosystem or nearby Recovery Colleges in order to avoid duplication of content (Meddings et al. 2015).

Importantly, there are **no assessments nor exams** at Recovery Colleges. However, some Recovery Colleges reported having a graduation, or an organised event to celebrate students' achievements (Anfossi 2017). The form that courses take also varies considerably, including:

- Short 'taster' courses designed to provide a preview to students before formal enrolment (Miles Rinaldi et al. 2012)
- Short single session 'courses' typically 2-3 hours in length (Duff 2016)
- Longer, spaced out courses delivered over several weeks (McCaig et al. 2014).

In most cases a variety of lengths and contact hours were present within any given Recovery College, affording students with ample choice to select from and make commitment to that aligned with their personal goals.

### Referral and support

In general, students are **not referred to a Recovery College**, but actively seek out and enrol in courses (Zucchelli & Skinner 2013). This is promoted to ensure students have a sense of agency and choice over their decision to enrol, and to further distinguish the service as an educational model rather than a clinical model of service (Jay et al. 2017). The place in which Recovery Colleges occupy within the wider service system is that of a **bridge between mental health services and communities** (Perkins et al. 2018). Perkins et al. (2018) detail that Recovery Colleges should be highly integrated with existing mental health services and draw upon the expertise within these services, as well as being highly integrated within communities. Thus, Recovery Colleges become highly visible to service users and service delivery organisations, facilitating referral between the two service systems (clinical and educational), and improving knowledge about the Recovery College in the community.

Whilst there is no requirement for referrals, in some cases referrals from local services may help promote visibility and awareness of a Recovery College (Secker & Wilson 2014, Chung et al. 2016, Naylor et al. 2017). Existing mental health services should be aware of the role and function of Recovery Colleges and may promote and inform their patients of the service as something they may wish to access in conjunction with their clinical support.

As discussed earlier in *Section 4.3.2*, **peer support** is often a key feature of Recovery Colleges. Sharing positive stories and giving feedback is reported to be beneficial and is a recurrent way of putting in practice the recovery approach (Anfossi 2017). The process of story-telling is powerful, as it validates a person's own account of what has happened to them (Psychiatric Disability Services of Victoria 2016). The SESRC have a Peer Learning Advisor who meets with students to set life and educational goals for their future and to discuss learning support needs through their ILP (Federation of Ethnic Communities' Councils of Australia 2015). Key examples of peer support functions included:

- **Role models (Meddings et al. 2014):** Peers with lived experience, who had participated in several courses at a Recovery College, would often develop into role models for other students new to the service. This involved acting as role models 'for hope and recovery' (n. p.), sharing their lived experience with other students and assisting to embed a culture of recovery throughout the College

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- **Peer Learning Advisors (McGregor et al. 2014):** These peer support roles involved peers assisting new students with identifying their needs, learning abilities and interests, and selecting courses to enrol in
- **Governance positions (Katherine Gill 2014):** This type of roll supports peers indirectly by advocating for students at board level
- **Co-facilitator (Perkins et al. 2018):** Peers can also co-facilitate courses with course tutors, and this is encouraged in the delivery of Recovery Colleges. As will discussed later, Recovery College alumni may engage in course co-facilitation, and act as an important source of peer-support in course delivery.

### Costs for students

Costs associated with Recovery College enrolment vary. Based on evidence from the peer-reviewed literature, access to Recovery Colleges within the UK is largely free (McGregor et al. 2014, Zabel et al. 2016, Newman-Taylor et al. 2016), however some may charge dependent on the student's circumstances (Mind Australia 2018). In Australian models, some services have a user pays system. Mind Australia offer a person's first course with them for free, with subsequent courses attracting a variable fee dependent upon the duration and location of the course (Mind Australia 2018). Examples of the pricing structure at Mind Australia Recovery Colleges are illustrated in *Table 4-6*.

**Table 4-6: Mind Recovery College pricing guide**

Course	Duration	Cost for student
Peer support work – what's it all about?	1 x 3 hour session	\$60.72
Reflection: a powerful tool for carers	2 x 2.5 hour sessions	\$121.44
Journaling for recovery	4 x 3 hour sessions	\$242.88
Anxiety – it's just not that simple	6 x 3 hour sessions	\$364.32

### Funding sources

There is limited information about the funding sources of Recovery Colleges in the peer-reviewed literature. However, based on the study of 39 Recovery Colleges in the UK, the majority of funding in that country comes from a trust fund (n=15) or Clinical Commissioning Groups<sup>1</sup> (n=13) (see *Table 4-7*).

<sup>1</sup> Clinical Commissioning Groups are National Health Service (NHS) organisations set up in England under the *Health and Social Care Act 2012* to organise the delivery of NHS services in England.

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**Table 4-7: Funding sources for UK Recovery Colleges** (Anfossi 2017)

Funding source	Number of colleges
Trust fund	15
Clinical Commissioning Groups	13
Charitable fund, grants and donations	5
Independent providers, or a combination of local underspends	5
Student fees and fundraising by staff and students	1
	39

### 4.4.3. Human resources

#### Staffing of Recovery Colleges

Within the peer-reviewed literature there was little information regarding number of contact hours for teaching and learning staff. Meddings et al. (2015) specify that a ratio of 5 hours of staff time produced 9 hours of student contact time. This included development of ILPs, planning and supervision.

It was highlighted elsewhere that there is significant **administrative burden** on staff when staffing levels are not planned or resourced appropriately. Zucchelli & Skinner (2013) detail how, upon starting the Recovery College in Central North West London, only “one part-time admissions officer was employed in the College, with the workload soon necessitating two full-time posts” (p. 187).

McGregor et al. (2014) report that in the third term of operation at the Nottingham Recovery College, 45 courses were ran for 275 enrolled students, supported by just 1.2 full-time equivalent (FTE) paid staff (see *Figure 4-4* for governance and staffing). The workload of staff may be moderated by selective employment within key Recovery College roles. This may include employing administration staff with prior experience in educational contexts to ensure frontline support of students is managed appropriately (McCaig et al. 2014).

Staffing often comprised a mix of professional staff, peer trainers, managers, administrators and volunteers (Skinner & Bailey 2015, McCaig et al. 2014, Frayn et al. 2016, Chung et al. 2016). This staffing mix could also comprise of employees with full-time hours and contractors engaged on a casual basis. The study of 39 Recovery Colleges in the UK reported that 92% of the colleges employed a core team of dedicated staff working specifically in the college (Anfossi 2017). In addition, 64% of colleges also employed additional professional trainers, staff from external and partner organisations, self-employed tutors, cleaners, classroom assistants, researchers and volunteers. An example of this mix can be found at the Central North West London Recovery College, which had the following mix of staff:

- **Admission Office and Management Staff:** Recovery trainers who are employed to work contracted weekly hours
- **Associate Peer Recovery Trainers:** Engaged when required to develop and deliver specific workshops and courses



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- **‘Spoke’ Associate Mental Health Practitioner Recovery Trainers:** Employees of CNWL or partner organisations, who can be engaged to co-develop or deliver workshops and courses on behalf of the College
- **Volunteer Recovery Trainers** (Skinner & Bailey 2015).

This base level of staff was then supported by additional specialists either with a lived experience of mental illness and other professionals in various course delivery fields (e.g. employment, law, finances) (Zucchelli & Skinner 2013).

In Sydney, the SESRC employs educators and casual employees according to need. This Recovery College appoints roles such as:

- **Consumer Educator:** provides expert consultation in the development and delivery of curriculum and course material
- **Carer Education Consultant:** provides expert consultation in the development and delivery of curriculum and course material
- **Consumer Research and Administrative Assistant:** provides expert consultation in the development and implementation of a comprehensive evaluation and research strategy, plus assistance in establishing a system for college registration and other administrative systems (Furst et al. 2016).

In 2014 the expression of interest for these roles detailed the payment rates as follows:

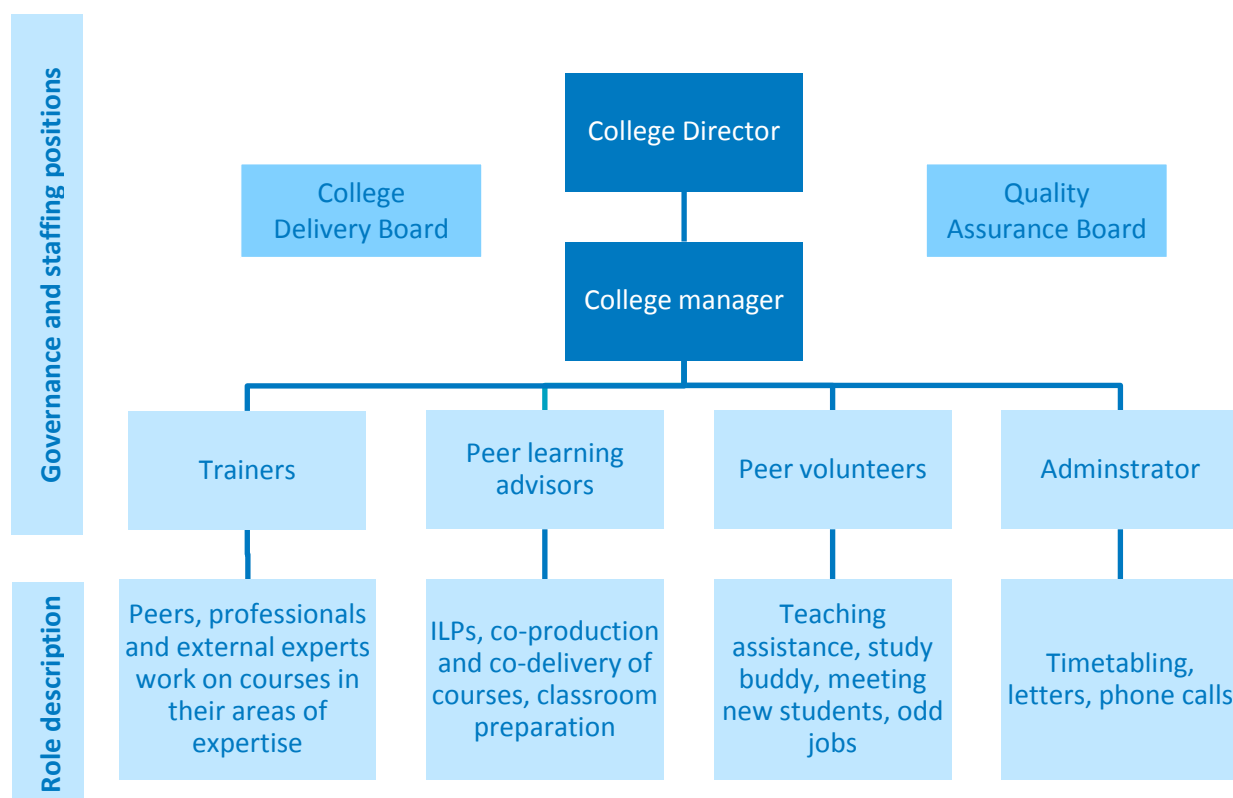
- For curriculum development, course writing, course piloting and review: \$40 per hour
- For course facilitation or presentations: \$62 per hour (South Eastern Sydney Local Health District NSW 2014).

The Mind Recovery Colleges in Australia have a College Central Campus with a team of six people (5.0 FTE) and a number of campuses in existing service areas within Mind, with each campus staffed by a Learning and Development Consultant (Hardy 2016b). The consultant must have a lived experience of mental illness and their role is to co-produce and co-deliver courses, coach new teachers, help students develop ILPs and evaluate courses.



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**Figure 4-4: Governance and staffing at Nottingham Recovery College (Repper n.d.)**



### Training

Training to deliver content in an engaging manner aligned with educational models is essential in delivering a Recovery College model of service delivery (Zucchelli & Skinner 2013). Supporting staff and extending their professional skills was approached in different ways. In some cases, clear structure was set up amongst staff to enable career progression, allowing for a natural course of professional development and mentorship. A key example of this was the training staff structure at the Hastings Recovery College (Meddings et al. 2014), illustrated in *Table 4-8*.

**Table 4-8: Staffing structure at Hastings Recovery College**

Staff level	Attributes	Role(s)
<b>Senior peer trainer</b>	Significant experience in teaching and peer support training, educated to degree level	Co-facilitation of courses
<b>Peer trainer</b>	<i>Preparing to Teach in the Lifelong Learning Sector</i> (PTLLS) certification	Co-facilitation of courses with senior peer trainers
<b>Volunteer assistant peer trainer or 'buddy'</b>	Working toward PTLLS certification	Supporting students to attend courses by accompanying them, helping with practicalities in the classroom

In other cases, care was taken when recruiting team members to ensure the right mix of skills was evident within the service delivery team (Zucchelli & Skinner 2013, McCaig et al. 2014, Chung et al.

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2016). This enabled staff to learn from one another, and in some instances, offer opportunities for mentorship to a new service delivery modality (Zucchelli & Skinner 2013).

At the South West London Recovery College, a short two-day 'train-the-trainer' course is provided for people who use the services, carers and staff (South West London and St George's Mental Health NHS Trust 2011). The course is designed to train participants in the skills required to deliver high quality interactive training at the college. The course includes lots of interactions and activities such as lectures, case studies, role plays, group discussions, skills practice and assessment tools.

### 4.4.4. The role of educators in Recovery Colleges

The role of educators in the delivery of Recovery Colleges was not explicitly covered in the literature. This included the development and delivery of courses. However, existing education institutions may form partnerships with the mental health organisation delivering a Recovery College (Perkins et al. 2018). In one case (Meddings, Byrne, et al. 2014), the role of training Recovery College staff was put to tender, inviting an educational institution with adult-learning experience to provide lifelong learning training to staff.

Elsewhere, the Dumfries and Galloway Wellness and Recovery College was setup in partnership within the University of Scotland (McCaig et al. 2014). In this Recovery College 'an administrator with an educational background' (p. 94) was employed to provide 'front line' contact with students and to assist them in developing their learning plans. 'Educational support' was provided to the peer trainers, however the extent to which this support was led by an educational expert was not discussed.

In their 10 year review of Recovery Colleges, Perkins et al. (2018) did not expand upon the precise role of educators in either the development or delivery of existing Recovery Colleges, however they do detail a partnership between the Solent Recovery College and the Highbury Further Education Centre, which allows students to access educative resources (Perkins et al. 2018).

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### 4.5. Models of intervention required to support recovery

This section discusses the theories underpinning Recovery College service delivery and evidence of emerging alternative modes of service delivery including online and blended learning.

#### 4.5.1. Recovery College models

As discussed in *Section 4.2.2*, Recovery College models, irrespective of location, adopt an **educational approach** to service delivery. Several pedagogical theories have contributed to the formulation of Recovery College model service delivery. McGregor et al. (2014) detail that theories of situated learning are embedded within the Recovery College ethos and are underpinned by students actively contributing to a social learning process, drawing upon their culture, contexts and experience to proceed “through co-construction and making meaning together” (p. 6).

Recovery principles such as hope, connectedness, identity, meaning, purpose and empowerment underpin Recovery College curricula (Federation of Ethnic Communities’ Councils of Australia 2015). The strength of this approach is the focus on rebuilding lives, rather than reducing symptoms, and the development of a partnership between equals, rather than patients and experts (Sutton 2015, Ashton 2017).

This strengths based approach is contrasted with the psycho-education approach, whereby the health professional takes charge and imparts knowledge upon the individual. At its core, it is a ‘philosophical shift’ (Roberts & Boardman 2014, p. 40) from treating, to learning and enabling (Hardy 2016a, Bourne et al. 2017, Windsor et al. 2017).

Another distinguishing feature of Recovery College models is that even though those with a lived experience of mental illness access a college, a college will generally hold ‘no clinical responsibility for students, treating them as self-determined, responsible adults’ (Zucchelli & Skinner 2013, p. 185). Whilst **no clinical responsibility** is taken, there is also the understanding that a Recovery College is a complementary service, delivered in concert with existing mental health care (Zucchelli & Skinner 2013, Secker & Wilson 2014).

Another theory which underpins the Recovery College model is Freire’s ‘**problem-posing dialogue**’ (Torre et al. 2017). Oh & DeVylder (2013) summarise this approach as,

When the teacher acknowledges the student’s authority, and engages in discourse with the student to raise critical consciousness. In true problem-posing dialogue, the teacher regards the student as an equal, and together they decide what to learn and how to learn it. This co-production is a central theme of Recovery Colleges and represents one of the unique instances in which Freire’s problem-posing dialogue is realized in practice’ (p. 3)

Despite the progressive philosophical and educational approaches, it is important to remain grounded and understand the capabilities and experience of peer trainers and staff of a Recovery College. Oh & DeVylder (2013) highlight that being able to engage in problem-posing dialogue takes practice and experience, and that ‘we must recognize that pedagogy is an incredibly complex activity, one that requires a tremendous amount of dedication, skill, and reflection’ (p. 3).

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### Online and blended learning

The delivery of Recovery College models in an **online mode** has not been evaluated within the peer-reviewed literature, although there are some Recovery Colleges that have engaged in online learning delivery, particularly where access is difficult for some students (McCaig et al. 2014). It is hypothesised that due to the fidelity criteria including the need for a physical location for a Recovery College, online delivery may have been overlooked in the development of many Recovery Colleges, though issues concerning resourcing and IT capabilities may also impede such development. Having a virtual environment requires balance due to risk of loneliness, limited support and isolation for students (Mental Health community coalition ACT Inc. 2017).

A report to stakeholders on the Recovery College project in Canberra listed a variety of modes of delivery that could be considered, including:

- Classrooms
- Online learning with a cloud IT environment
- Outreach courses with considerations of language, CALD and English as a Second Language (ESL)
- Use of Skype for those who cannot travel or leave home
- Use of smartphone and software applications (Mental Health community coalition ACT Inc. 2017).

In a conference presentation, Williams (2016) describes the development of “sophisticated video-recording and streaming software and hardware that could livebroadcast (sic) college sessions to users in their own homes” (p. 1) to address inclusivity issues in a UK Recovery College. Further evaluation of this particular instance of online delivery is yet to be published. Elsewhere, blended learning environments are discussed by McCaig et al. (2014), however given this paper concerned the establishment of a Recovery College within an existing university location, the necessary technological supports were likely already in place.

Finally, in Australia, the Mind Recovery College had planned to deliver a blended learning model to supplement face-to-face activities and in some cases, offer courses wholly online (Mind Australia 2012). At present, Mind is yet to implement an online learning framework within their existing Recovery Colleges.

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### 4.6. Evaluation

Evaluation processes varied considerably between Recovery Colleges and within the peer-reviewed literature. Despite this heterogeneity, there were instances of consistent outcome measure usage. For more detailed evaluative processes, Recovery Colleges have employed mixed-methods approaches that investigate student-level outcomes and service ecosystem-level outcomes (outcomes for ancillary health and social services, e.g. reduced usage of emergency services) of Recovery College practice. This final section will discuss analysis of the literature relating to:

- How student outcomes are evaluated
- Outcomes of attending Recovery Colleges for students
- How service ecosystem outcomes are evaluated
- The influence of Recovery Colleges on the service ecosystem
- Future directions for Recovery College evaluation.

#### 4.6.1. Student level

##### Evaluation methods

In all cases identified in the literature, Recovery Colleges adopted routine **student feedback** processes at course completion to inform ongoing development of curricula and gauge student satisfaction. These often took the form of standardised feedback forms with both Likert scale measures and opportunity for open-ended, qualitative feedback (Fraysn et al. 2016, Zucchelli & Skinner 2013, Meddings et al. 2015) collected at the end of a course. ILPs can also form part of the evaluation as students are asked to rate their health status, social inclusion and attainment of goals (Federation of Ethnic Communities' Councils of Australia 2015). The pop up Recovery College model encouraged students to keep a recovery journal about their experience of the course, which can also be an opportunity for qualitative feedback throughout the course (Burhouse et al. 2015).

A study of the 39 Recovery Colleges in the UK reported that 92% of colleges collect outcome data from various sources (Anfossi 2017). This included student feedback from each individual course, as well as information about changes in employment status of students, standardised *Recovery* or *Quality of Life* questionnaires and specific NHS outcome measures investigating student experience and self-rated feelings of hope and agency.

A common method of evaluating student outcomes was the Inclusion Web (Skinner & Bailey 2015, Zucchelli & Skinner 2013), a tool that is used to assess 'changes in social networks and environment while supporting the shared perspective of social inclusion' (Hacking & Bates 2008, p. 4). This was used as a more holistic measure of social inclusion, allowing for a Recovery College to identify how a person's social life changes over time.

For more formal and academic evaluations, several validated quantitative outcome measures were detailed within the peer-reviewed literature as suitable for Recovery College evaluation, and were often employed pre and post service usage. Meddings et al. (2015) employed the following quantitative measures for their evaluation of the Sussex Recovery College:

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- Manchester Short Assessment of Quality of Life
- CHOICE Short-form (assesses psychological recovery and mental health)
- Warwick and Edinburgh Mental Wellbeing Scale (Short form).

As can be seen, there was considerable heterogeneity of quantitative outcome measures within the literature, and in some cases outcome measures may be best aligned with local, standardised outcome measurement practice. Elsewhere, the Questionnaire about the Process of Recovery (QPR) has been used (Kaminskiy & Moore 2015) to evaluate recovery processes and outcomes. For an evaluation of a Recovery Education Program within a University, Dunn et al. (2008) employed the Brief Quality of Life Interview, The Empowerment Scale and The Personal Vision of Recovery Questionnaire.

Qualitative methods of inquiry identified included interviews and focus groups, depending on the overarching aims of the evaluation questions and desires of the student cohort (Cameron et al. 2016, Kaminskiy & Moore 2015). A holistic approach has also been employed utilising Weavers Triangle and the 'collation of digital stories and use of photos and images' (McCaig et al. 2014, p. 95) to evaluate the process of recovery.

### Outcomes

Student outcomes were almost universally positive, and where outcomes did not align with desired outcomes of a Recovery College it was commonly attributed to incongruence between service delivery and key Recovery College fidelity criteria. The following section details a synthesis of the literature related to student outcomes of attending a Recovery College. They are presented in order of frequency each outcome was referred to within the literature. Student outcomes included:

- Developing a sense of identity and hope
- High satisfaction levels with service delivery
- An increase in pathways toward future opportunities
- Lifestyle and social benefits
- Improvements in wellbeing indicators
- Poor outcomes due to service model fidelity.

### Developing a sense of identity and hope

**Reclamation of identity** and a renewed sense of hope were significant student outcomes discussed commonly within the peer-reviewed literature. Reclamation of identity refers to the experience of reclaiming one's own sense of self, which at times can be lost when interfacing with clinical mental health services (Jay et al. 2017). Perkins et al. (2017) detail one student who found the college had enabled them to develop a sense of self-esteem, and confidence in their own knowledge, abilities and skills. For many students, attending a Recovery College 'enables them to redefine their personal experience of mental health issues, (re)create an identity beyond their illness and explore new social networks and supports' (McGregor et al. 2014, p. 13). Students reported that learning about their mental illness, helped them learn about themselves and how to control their symptoms (Watts et al. 2014)

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In addition to a reclamation of identity, students felt a renewed sense of hope while attending Recovery Colleges (Sommer et al. 2017). Rinaldi et al. (2012) found that students felt more hopeful for the future, whilst elsewhere, hope was related to feeling more hopeful about recovery, either for oneself or for someone a student was supporting (Bourne et al. 2017).

### Satisfaction with service delivery

Satisfaction with Recovery College courses and service delivery was routinely reported as high within the peer-reviewed literature. Several studies reported **higher than 90% satisfaction** among students and staff students, with similar results regarding willingness to recommend attending a Recovery College to others (Zucchelli & Skinner 2013, Meddings et al. 2014, Meddings et al. 2015, Perkins et al. 2017, Frayn et al. 2016, Arbour & Stevens 2017). Recovery Colleges are popular with students as they engage those who find traditional day services unattractive (Slade et al. 2017).

The evaluation of the Greenwich Recovery College found that students missed the Recovery College and the student body when the course had ended (Wels 2016). As such, the college has been working on transitioning students out as well as providing a virtual community for support. One of the student bodies took a proactive approach to transition and received charitable funding to set up an ongoing reading and meeting group, open to all.

In a report on the early outcomes of the Mind Recovery College, Hall et al. (2016) detail that satisfaction was highest in relation to the respect that staff showed toward students and the feelings of safety and comfort the Recovery College afforded students, sentiments that were also echoed in Perkins et al. (2017) and Thornhill & Dutta (2016). Moreover, students at the Mind Recovery College were satisfied with the neutral power dynamics between staff and student and the approachability and professionalism of staff (Hall et al. 2016). In addition to this, peer educators from the SESRC reported that they benefited from co-developing and co-delivering courses as they were able to share and support their fellow peers (Mental Health Commission of NSW 2014).

### Pathways toward future opportunities

The pathways that are opened up to students once attending a Recovery College were also a prominent outcome within the peer-reviewed literature. In some cases, a Recovery College was a **gateway through to tertiary education**, particularly for those who did not feel comfortable of attending a tertiary institution (Hall et al. 2016). Similar findings have been reported in the UK, with Perkins et al. (2012) finding that 70% of students who completed a Recovery College course either continued with further education or took part in volunteering or employment. The evaluation of the South Essex Recovery College reported that 61% of students felt more hopeful for the future because they attended the course (Kaminskiy & Moore 2015). 85% of respondents either agreed or strongly agreed to the statement 'I have learnt new skills that will help me be able to do things I want to do in my life'.

The opening up of pathways was also evident within specialised Recovery College models. Findings were similar within the Recovery College developed for those living with dementia and their carers (Duff 2016), with students going on to enrol in further courses. Whilst for the Canadian Recovery College aimed at those living with housing instability and a mental illness, '39.7% of students continued their studies and participated in programs offered by other community organizations' (Chung et al. 2016, p. 853). This was attributed to the Recovery College's ability to develop a robust peer network, and a focus on educational and vocational skills (Chung et al. 2016, Zabel et al. 2016).



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### Lifestyle and social benefits

Students derived significant social benefits from attending a Recovery College, **reducing feelings of isolation**, and providing them with an opportunity to connect with others who have a lived experience of mental illness (Windsor et al. 2017). Students at the Recovery College for those living with housing instability praised the ability of the college to bring people together, reporting that while ‘we learn a tremendous amount of things in the classes as well, the friendships with other members and the facilitators are what helped me the most’ (Chung et al. 2016, p. 853).

Reducing social isolation is an advantage of the Recovery College model over traditional, one-on-one forms of psychotherapy. By nature, Recovery Colleges are social, just like traditional education institutions. Furthermore, they promote the integration of diverse people with varied personal and professional backgrounds due to their inclusive principles. Sommer et al. (2017) reported that by learning with others who have a lived experience, students felt their own experiences were affirmed, and it reassured them that others had similar experiences to them. Even within a secure setting Recovery College, a student voiced that it ‘was great to meet some ex-patients who are doing well in the community [...] made me feel less anxious about the future’ (Frayn et al. 2016, p. 33).

Meddings et al. (2015) found that attendance at a Recovery College significantly increased the number of friends that ‘students felt like they could talk to about mental health and recovery’ (n. p.). This demonstrates that by reducing the stigma concerning mental illness students were able to interact more comfortably with friends, particularly when discussing issues related to their own mental illness and recovery trajectories.

For many students who had graduated from a Recovery College course, returning to the College to co-facilitate courses and work or volunteer as a peer support worker was a common occurrence (Meddings et al. 2015). This was an important aspect of alumni engagement that could be explored further in the development of future Recovery Colleges.

### Improvements in wellbeing indicators

Improvements in clinical and wellbeing indicators were reported within the peer-reviewed literature, however it is generally regarded that higher quality evaluation concerning clinical and wellbeing indicators is required (Mcgregor & Hoban 2015). Bourne et al. (2017) found that students evinced significant improvement in Health of the Nation Outcome Scores between before and after attending a Recovery College, whilst Naylor et al. (2017) detail improvements in Process of Recovery score before and after Recovery College attendance, though the opposite was found by Kaminskiy & Moore (2015) in an earlier study.

In an evaluation of the Mid-Essex Recovery College, it was found that both males and females showed increases in wellbeing measures, with those aged between 30 and 39 years showing the greatest increase in wellbeing (Secker & Wilson 2014). Quality of life measures have also shown improvements attributed to Recovery College attendance (Meddings et al. 2015, Dunn et al. 2008).

Despite these promising findings, there is considerable work to be done regarding evaluating clinical outcomes, with very little data focusing on specific mental health measures. An explanation as to why clinical measures are poorly represented in the Recovery College evaluation literature may be attributed to the fact that Recovery Colleges are not designed nor based upon a clinical intervention ethos, and are situated wholly within the educational philosophy.



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### Poor outcomes due to service model fidelity

Some studies within the peer-reviewed literature detail less positive outcomes and experiences associated with attending a Recovery College (Dunn et al. 2008, Rinaldi et al. 2012, Secker & Wilson 2014, Gill 2014). For the majority, poor or lack of beneficial outcomes were associated with either lack of adherence to Recovery College fidelity criteria or service design and staffing issues.

The quasi-experimental study by Dunn et al. (2008) presented some of the few findings that found poorer outcomes for students when compared with those accessing treatment as usual. There were, however, significant divergences in the experimental intervention from what we now consider a contemporary Recovery College to look like. These differences included:

- No significant element of co-production with students
- A compulsory recovery course (Recovery Colleges should increase choice and autonomy).

Whilst the study observed improvements in subjective feelings of empowerment, quality of life and attitudes toward recovery, there were no significant improvements over and above those achieved by the control group across various clinical indicators (e.g. measures of depression, anxiety, obsessive compulsive behaviour), and no improvements when compared with controls on generalised mental health scales (Dunn et al. 2008). To date, the study by Dunn et al. (2008) presents the only quasi-experimental research study on a model similar to that of a Recovery College, and in particular is the only study to comprehensively assess clinical indicators.

Where other negative or neutral experiences occurred, it was primarily associated with issues regarding course format and staffing. In an annual report by Rinaldi et al. (2012) there was significant variance between Recovery College locations within the South West London hub and spoke model of Recovery Colleges in terms of student experience. This variance prompted the Recovery Colleges to increase focus on quality assurance between campuses to ensure students, no matter which campus they attended, received the same high-quality experience.

Secker & Wilson (2014) reported that a lack of variation in course availability resulted in some students calling for additional courses that focused on other topics outside of mental health. Finally, for some peer educators, there were at times feelings of being overwhelmed by the amount of preparation and work, particularly when other staff left planning to the last minute (K H Gill 2014). This highlights the need to manage all staff and set expectations when developing a Recovery College service.

### 4.6.2. Service ecosystem level

Outcomes related to the service ecosystem were prominent within the peer-reviewed literature. The service ecosystem in this case refers to:

- Health and social services outside of the Recovery College (e.g. hospitals, employment services, mental health services)
- Staff from existing services outside of the Recovery College
- Other external stakeholders (Government and NGOs)

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### Evaluation methods

At a service ecosystem level of evaluation, it was more common for quantitative measures to be employed (Bourne et al. 2017). Key examples include the measurement of:

- Number of hospital admissions pre and post Recovery College access
- Use of community mental health services pre and post Recovery College access
- Cost savings based on reduced service system access
- Entrance to paid employment or further studies post-Recovery College access (McGregor et al. 2014, Zabel et al. 2016, Bourne et al. 2017).

### Outcomes

Service ecosystem outcomes can be characterised in two different aspects, the first being impacts upon clinician and organisation attitudes toward service delivery, and the second focusing on reduced service usage (including reduced usage of both acute hospital and community-based care).

#### Clinical staff and organisational impact

Numerous peer-reviewed publications mention the **transformative nature** of the Recovery College model for existing clinical staff and mental health organisations (Frayn et al. 2016, Watts et al. 2014, Zucchelli & Skinner 2013, Perkins et al. 2017, Sommer et al. 2017). Sommer et al. (2017) detail how clinical staff gained new insight into the process of recovery through taking and co-facilitating courses at a Recovery College, so much so that the experience was have a positive impact on their clinical practice:

*They described relinquishing judgemental and controlling attitudes and focussing on the facilitation of consumer choice and decision making (p. 23).*

Elsewhere, participation in Recovery College activity served to break down power imbalances often found in traditional clinical practice, with a clinical practitioner in the study on Recovery College delivery within a secure setting (Frayn et al. 2016) stating that the Recovery College has:

*Changed the way I engage with people. There's always a power dynamic in any service where people are detained, particularly secure services, and this is something that can often flatten the hierarchy, (encourage us to) develop the role of supporting someone, facilitating the 'working with' not the 'doing to' (p. 31).*

Some apprehension was felt by staff accessing the Recovery College for the first time as a student. It was recognised that once a clinical staff member enters the Recovery College, they no longer identify as a psychologist or psychiatrist, but identify as a student of the College (Watts et al. 2014). Clinical staff realised that the Recovery College was not about 'bashing' existing clinical service models, but understanding recovery and mental illness in a different mode of service delivery (Zucchelli & Skinner 2013, Watts et al. 2014).

Challenges were faced when co-learning principles did not adhere to key Recovery College fidelity criteria. A key example of this was when co-learning and co-facilitation principles were not adhered to, and when the breaking down of power dynamics became compromised (e.g. staff not removing their clinical position badges in class, or when staff made it clear they were not service users but clinical staff

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in class discussions) (Perkins et al. 2017). Despite these challenges, Perkins et al. (2017) noted that when the Recovery College model is executed well, it can have significant benefits for clinicians, their wellbeing and practice outside of the college, highlighting a time and cost effective mechanism for professional development and wellbeing of staff.

Currently there is limited evidence of service ecosystem impact in the grey literature. The Mind Recovery College in Australia report that they have built a reputation for providing an innovative and complementary support for recovery, with local organisations connecting and partnering with the college (Hardy 2016a).

### Reduced acute and community mental health service usage

One of the most promising outcomes found in select Recovery College evaluations has been the **reduction in acute and community mental health service use** by students of Recovery Colleges (Ashton 2017). In the South west London Recovery College Annual Report, Rinaldi et al. (2012) report that for those who attended a course, follow-up six months after completion revealed that there was a reduction in both community mental health contacts and hospital bed days, and the reduction in community mental health contacts was significant for those who had completed 70% or more of their course. However, these results should be interpreted with caution as information regarding variance of the data and effect size of the change was not provided.

Naylor et al. (2017) have reported reductions in GP visits, emergency room attendances, police contacts, contacts with psychiatric liaison teams and crisis lines following participation in a Recovery College courses. Whilst Bourne et al. (2017) have reported significant positive effects including reduction of occupied bed days, admissions and community contacts in the following 18 months post-Recovery College access when compared to the 18 months prior to Recovery College access. The authors calculated that reduction in service access 'equates to non-cashable cost-savings of £1200 per registered student and £1760 for students who completed a course' (Bourne et al. 2017, p. 1), though further work is required to establish a causal relationship.

In Australia, a social return on investment analysis of the peer-operated Flourish Australia service reported that in 2014, for every \$1 invested, approximately \$3.27 of social and economic value was created for stakeholders (Social Ventures Australia 2017). The analysis also found that there was less pressure on local services, specifically lower hospital admissions and re-admissions and shorter lengths of stay during admissions.

### 4.6.3. Future directions for evaluation

Whilst some wider service ecosystem outcome evaluations have been conducted, this is an area where increased focus is required to determine the impact of Recovery Colleges on service access and engagement with other sectors such as employment and further education (Zabel et al. 2016). The development of standardised measures and the collection of minimum dataset information 'on socio-demographic data, student experience, process measures, and outcome measures' (Mcgregor & Hoban 2015, p. 16) has been highlighted as a sector priority.

Another key area for evaluation development is the evaluation of how different models of Recovery Colleges, different locations, and varied organisational links impact upon student and service ecosystem outcomes. For example, Meddings et al. (2015) raise the question of whether Recovery Colleges should

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be co-located with mental health services, given the transformational power a Recovery College has on existing mental health service delivery. The same authors also raise the question regarding what key partnerships make a Recovery College work, and whether 'hub and spoke' models of service delivery can maintain adherence to key fidelity criteria.

Finally, Sommer et al. (2017) highlight the need for more robust fiscal cost-benefit analyses to persuade decision makers and funders to place greater resources into developing the Recovery College model. This may include evaluating cost-savings due to reduced mental health service usage and acute care access.

## 5. Conclusion

Recovery Colleges are diverse, owing largely to the key principle of co-production. Co-production with those with a lived experience may influence the development and delivery of a Recovery College, particularly as different populations will bring different ideas to co-production. They may evolve differently depending upon the context in which they situate themselves, and the people accessing and co-producing them over time. As detailed in Sections 4.2.1, 4.2.2 and 4.2.3, there are common attributes that define what a Recovery College is and what a Recovery College is not (Meddings et al. 2015). These attributes will be discussed in the following section in relation to the development of a Recovery College model in WA.

### 5.1. Considerations for the WA context

The geography and socio-demographic compositions of WA are unique and distinct from existing locations where Recovery Colleges currently operate. With two metropolitan PHNs and one regional, rural and remote PHN encompassing seven highly diverse regions in terms of population density, the challenges are evident in developing a Recovery College model for WA. Further, the desire to develop a service delivery model focused on co-occurring mental health and AOD issues adds complexity, but drives opportunity for the WA Recovery College model. Analysis of the peer-reviewed and grey literature has been drawn upon to detail how the challenges of geography and socio-demographics may be overcome.

For WA, the hub and spoke model will assist in increasing access for some hard to reach populations. However, consideration of online models running alongside a hub and spoke model may address some challenges presented by a highly dispersed and diverse population. The following areas will be discussed in relation to WA's unique context:

- Geography
- Socio-demographic composition
- Co-occurring mental health and AOD service delivery.

#### 5.1.1. Geography

The first challenge of geography may be overcome through innovative service delivery, including:

- Development of a hub and spoke service model
- Delivery of 'pop-up' Recovery Colleges
- Development and trialling of digital delivery of Recovery College services
- Establishing strong regional partnerships with existing service providers within and outside of the mental health sector.

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### The Hub and Spoke model

The Hub and Spoke model is consistently employed in jurisdictions overseas whereby a central and main hub of service delivery is developed, while subsequent 'spoke' service sites are developed to deliver Recovery College services to regional areas where access to the Hub service may be challenging or impractical. While in the UK Hub and Spoke models may be geographically less dispersed in nature, it may be the case that in WA a major hub can exist in the Perth metropolitan area, whilst spokes can be developed in regional centres to deliver smaller scale Recovery College services.

### Delivery of 'pop up' Recovery Colleges

The one example of a 'pop up' Recovery College style of service delivery offers another approach for the WA model to consider in service delivery to rural, regional and remote populations. The pop up model in the UK was designed for these harder to reach populations, and was delivered in partnership with local services (including educational facilities).

### Digital access to Recovery Colleges

Just as the tertiary education sector has modernised and implemented technological solutions to increase access for those who may be living remotely, WA's unique geographical context may be a catalyst for exploring online delivery alongside a hub and spoke Recovery College model. Overseas, geographical constraints are not as prevalent as they are in WA, and technological delivery of Recovery College services has not progressed significantly, nor has it been evaluated and compared with existing face-to-face service delivery models.

There is great opportunity to develop online modes of access to WA Recovery Colleges that increase access for those living in regional, rural and remote areas, and for those who may be more comfortable engaging with a Recovery College in an online format. Further, an opportunity is presented to innovate within the Recovery College space, and inform the professional, academic and Recovery College community of novel methods of service delivery.

### Establishment of strong partnerships

Strong partnerships with mental health, AOD and other health, social and educational organisations and services will be important in developing a Recovery College model that caters for WA communities. Delivering Hub and Spoke, pop-up and digital Recovery College service models will rely upon services working together, often over long distances. This will require co-ordination and oversight, and most importantly, a shared vision for what the Recovery College aims to achieve.

#### 5.1.2. Socio-demographic composition

Perth has experienced substantial growth in cultural diversity, whilst regional, rural and remote populations include greater proportions of Aboriginal and Torres Strait Islander people (Department of Local Government and Communities 2013, Perth South PHN 2017). This diversity presents challenges but also opportunity in the development of a Recovery College service model for WA.

At present, there is very little understanding of how Aboriginal and Torres Strait Islander people access and experience Recovery Colleges in Australia. Whilst some Colleges offer suicide prevention training

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related to Aboriginal and Torres Strait Islander populations, these courses are not substantially co-produced. There is an opportunity for the WA Recovery College model to demonstrate authentic co-production and co-facilitation with the Aboriginal and Torres Strait Islander community, and it should be acknowledged that through this process, adherence to existing Recovery College fidelity criteria may not be possible, nor desirable, particularly as Recovery Colleges have developed in predominantly overseas or mainstream contexts.

Another challenge (or opportunity) is the growing multicultural composition of WA, and in particular, Perth's greater suburban surrounds. The development of a Hub location in Perth will need to be cognisant of and responsive to the needs of this community.

### 5.1.3. Co-occurring mental health and AOD service delivery

Evidence within the literature on Recovery College models focused on co-occurring mental health and AOD issues was scarce. In most cases, co-occurring mental health and AOD focus manifested in the form of a Recovery College course, rather than a broad focus of a Recovery College itself. This allows for those experiencing mental illness and AOD issues, those supporting someone with co-occurring mental health and AOD issues, or professionals interested in co-occurring mental health and AOD issues the opportunity to engage with such content via coursework. The Commission may wish to consider further how co-occurring mental health and AOD issues may fit within the Recovery College model, and work toward co-production of courses with those affected by or involved in co-occurring mental health and AOD issues in some way.

## 5.2. Review of the WA Recovery College Business Model and Plan

As part of the literature review, AHA was tasked with reviewing the current WA Recovery College Business Model and Plan in light of the findings from the literature review. The following are key points where the WA Recovery College Business Model and Plan had inconsistent or contradictory information to what was found in the literature.

### 5.2.1. Business Plan discussion points

#### Section 2.7 – Key markets

The Business Plan discusses a number of key markets, including people with a lived experience, their supporters, family and significant others. Within the literature, existing professional and clinical staff within the mental health and AOD sectors were also seen as an additional key market, particularly given the observed organisational and professional benefits derived from staff participating in a Recovery College model.

#### Section 4 – Product

The Business Plan outlines two key products, the first of which details 'the courses and content that is delivered to people with a lived experience'. Within the literature, language reflected a more inclusive tone. For example, instead of 'doing things to people', Recovery Colleges emphasised working 'in

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concert with', 'in collaboration with' or 'in co-production with' to align more closely with Recovery College principles of co-production and co-delivery.

### Section 7.3 – Location and timetabling

The Business Plan states that the establishment of training/class rooms and an office would be scoped as part of service development. A frequent marker of high quality Recovery College practice was the ability for students and staff to access a cafeteria/lunch space and a library to study (even if only in the form of digital access on an available computer). These additional services are commensurate with existing Recovery College design. It is, however, recognised that many Recovery Colleges proceed without extensive resources or space.

### Section 7.4.3 – Dual delivery

Throughout the literature, management and training of peer facilitators was highlighted as vital to the success of a Recovery College, and the experience of students. The Business Plan did not explicitly consider how professional development and skills training in pedagogical practices can be incorporated into the Plan and Model, and how mentorship processes may be put in place.

### Section 7.4.5 – Course development and intellectual property

Within the literature, administration and student contact was routinely reported as considerable. In one case, facilitators dedicated a ratio of 5 hours of staff time to every 9 hours of student contact. Focus on resourcing administrative positions should be considered within the Business Plan and should take into account the high burden of administration into employment of staff for a Recovery College.

## 5.2.2. Business Model discussion points

### Section 2.2 – Core fidelity criteria

The Business Model states that 'The Recovery College is (and must remain) an Educational facility. It is not a mental health service and must not be, become or be substantially controlled by, a mental health service provider'. Whilst Recovery Colleges are educational institutions, this should not preclude mental health services from having involvement in their delivery. In existing Australian Recovery Colleges, mental health providers are substantially involved in the delivery of courses. There are advantages to this approach, including greater integration of service delivery, ease of access and promotion of the Recovery College, and the benefits derived from mental health staff by taking part in Recovery College courses.

Under the inclusive banner, the Business Model states that the 'College offers learning opportunities to students of all abilities, cultures, ages and experiences'. In many Recovery College models overseas and within Australia, an age of 18 or older is commonly cited. If developing a service for all users regardless of age, attention should be paid to differentiating course co-production and co-delivery for those under the age of 18.



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### 5.3. Statement of best practice

The criteria for Recovery Colleges are prominent in the peer-reviewed and grey literature, and offer a comprehensive base with which to ground the development of the WA Recovery College model. Whilst these fidelity criteria represent existing Recovery Colleges, it should be noted that in developing new Recovery College models, the process of co-production may direct service development in divergent ways. Further, the considerations for local context may necessitate deviation away from certain criteria, e.g. the delivery of online courses to accommodate for geographical barriers to access.

Based on established key fidelity criteria in the peer-reviewed literature (Meddings et al. 2015), a Recovery College is based on several key principles. Recovery Colleges:

- Are firmly grounded in an **educational approach**
- Are underpinned, always, by **co-production**
- Always recognise the **strengths of students**
- Have a **physical location**
- Are **person-centred**
- Are **not a replacement** for traditional mental health or AOD services, but supplement them
- Deliver a **progressive education** that works toward further study or employment
- Are **community facing**, and engage with the people, services and organisations around them
- Are **inclusive**.

By undertaking co-production processes with the community, the development of a WA Recovery College model may evolve differently in response to the unique geography and demography of the state. Adherence to these key principles should not be used as a marker for success, but they can provide an evidence-base on which the Commission can co-produce the Recovery College model for WA.

# Appendix A. Cited references

## A.1. Cited references

Anfossi, A 2017, *The Current State Of Recovery Colleges In The UK: Final Report, ImROC*.

Arbour, S & Stevens, A 2017, *A Recovery College In Canada: An Innovative Means Of Supporting And Empowering Individuals With Severe Mental Illness*, *Canadian Journal of Community Mental Health*, vol. 36. no. 3, pp. 1–5.

Ashton, L 2017, *Recovery Colleges: An Overview Of The International Experience*, AOD Collaborative, Manukau.

Bourne, P, Meddings, S, & Whittington, A 2017, *An Evaluation Of Service Use Outcomes In A Recovery College*, *Journal of Mental Health*, pp. 1-8.

Burhouse, A, Rowland, M, Marie Niman, H, Abraham, D, Collins, E, Matthews, H, Denney, J, & Ryland, H 2015, *Coaching For Recovery: A Quality Improvement Project In Mental Healthcare*, *BMJ Quality Improvement Reports*, vol. 4, no. 1.

Cameron, J, Reardon, M, 2016, *Building Resilience For Mental Health Recovery: A Recovery College Collaboration*, *British Journal of Occupational Therapy*, vol. 79, pp. 14-14.

Camus, E & Goodchild, S 2015, *Facing The Axe: Recovery “Colleges” Preventing A Mental Health Crisis Hit By Funding Crisis*, *Campaigners Warn*, *Daily Mail Online*, viewed 23 January 2018, <<http://www.dailymail.co.uk/health/article-3174333/Facing-axe-recovery-colleges-preventing-mental-health-crisis-hit-funding-crisis-campaigners-warn.html>>.

Chung, TE, Curwood, SE, Thang, H, Gruszecki, S, & ... 2016, *Introducing A Recovery Education Centre For Adults Experiencing Mental Health Challenges And Housing Instability In A Large Urban Setting*, *International Journal of Mental Health and Addiction*, vol. 15, no. 5, pp. 850-855.

Coughlan, S 2013, *Homeless Sign Up For Recovery College*, *BBC News*, viewed 16 February 2018, <<http://www.bbc.com/news/education-21236680>>.

Department of Local Government and Communities 2013, *Cultural Diversity In Western Australia: A Demographic Profile*, Perth.

Duff, C 2016, *Exploring The Use Of A Recovery College For Older People With Dementia In The UK*, *British Journal of Occupational Therapy*, vol. 79, pp. 79-79.

Dunn, EA, Chow, J, Meddings, S, & Haycock, LJ 2016, *Barriers To Attendance At Recovery Colleges*, *Mental Health and Social Inclusion*, vol. 20, no. 4, pp. 238–246.

Dunn, EC, Rogers, ES, Hutchinson, DS, Lyass, A, Wilson, KLM, Wallace, LR, & Furlong-Norman, K 2008, *Results Of An Innovative University-based Recovery Education Program For Adults With Psychiatric Disabilities*, *Administration and Policy in Mental Health and Mental Health Services Research*, vol. 35, no. 5, p. 357.

Ellis, LA, McCabe, K, Davenport, T, Burns, JM, Rahilly, K, Nicholas, M, & Hickie, IB 2015, *Development And Evaluation Of An Internet-based Program To Improve The Mental Health And Wellbeing Of Young Men*,

## Appendix A. Cited references

---

*Interactive Technology and Smart Education*, vol. 12, no. 1, pp. 2–13.

Federation of Ethnic Communities' Councils of Australia 2015, *Pathways To Better Mental Health*, FECCA.

Frayn, E, Duke, J, Smith, H, Wayne, P, & Roberts, G 2016, *A Voyage Of Discovery: Setting Up A Recovery College In A Secure Setting*, *Mental Health and Social Inclusion*, vol. 20, no. 1, pp. 29–35.

Furst, M, Salinas-Perez, J, Hopman, K, Maas, C, Fernandez, A, Xu, T, Alvarez-Galvez, J, Prigent, A, Gandre, C, & Salvador-Carulla, L 2016, *The Integrated Mental Health Atlas Of The South Eastern Sydney Local Health District*.

Gill, KH 2014, *Recovery Colleges, Co-production In Action: The Value Of The Lived Experience*, *Health Issues*, vol. 113, no. 10.

Guo, S, Nguyen, H, Weiss, B, Ngo, VK, & Lau, AS 2015, *Linkages Between Mental Health Need And Help-seeking Behavior Among Adolescents: Moderating Role Of Ethnicity And Cultural Values.*, *Journal of counseling psychology*, vol. 62, no. 4, p. 682.

Hacking, S & Bates, P 2008, *The Inclusion Web: A Tool For Person-centered Planning And Service Evaluation*, *Mental Health Review Journal*, vol. 13, no. 2, pp. 4–15.

Hall, T, Brophy, L, & Jordan, H 2016, *A Report On The Early Outcomes Of The Mind Recovery College*.

Hall, T, Brophy, L, Jordan, H, Hardy, D, Belmore, S, Scott, A, & Thompson, H 2016, *Co-Producing The Journey To Recovery - The Mind Recovery College*.

Hardy, D 2016a, *The MHS AWARD : Mind Recovery College*.

Hardy, D 2016b, *"I Feel Like A Real Person And Not A Diagnosis": The Mind Recovery College, A New Space For Discourse And Working Together For Recovery*, *Debra Parnell*.

Harper, L & McKeown, M 2017, *Why Make The Effort? Exploring Recovery College Engagement*, *Mental Health and Social Inclusion*, vol. 22, no. 1, pp. 27-33.

Health Service Executive & Advancing Recovery in Ireland 2016, *Advancing Recovery In Ireland: A Guidance Paper On Implementing Organisational And Cultural Change In Mental Health Services In Ireland*.

Jay, L, Macadam, B, Gardner, P, & Mahboub, L 2017, *Hope Headquarters: Recovery College*, *Health Promotion Journal of Australia*, vol. 28, no. 2, pp. 170-173.

Jennings, H, Toney, R, Slade, M, Bates, P, Taylor, A, & ... 2017, *The RECOLLECT Project: First Steps In The Scientific Evaluation Of Recovery Colleges*.

Kaminskiy, E & Moore, S 2015, *South Essex Recovery College Evaluation*, [arro.anglia.ac.uk](http://arro.anglia.ac.uk).

Kelly, J, Gallagher, S, & McMahon, J 2017, *Developing A Recovery College: A Preliminary Exercise In Establishing Regional Readiness And Community Needs*, *Journal of Mental Health*, vol. 26, no. 2, pp. 150–155.

Machin, K & Repper, J 2013, *Recovery: A Carer's Perspective*, Centre for Mental Health, Implementing Recovery through Organisational Change Briefing.

McCaig, M, McNay, L, Marland, G, Bradstreet, S, & Campbell, J 2014, *Establishing A Recovery College In*

## Appendix A. Cited references

---

A Scottish University, *Mental Health and Social Inclusion*, vol. 18, no. 2, pp. 92–97.

McDonagh, M 2014, *Mental Health: Happy To Enrol In College Of Recovery*, viewed 16 February 2018, <<https://www.irishtimes.com/life-and-style/mental-health-happy-to-enrol-in-college-of-recovery-1.1945397>>.

McGough, S, Wynaden, D, & Wright, M 2018, *Experience Of Providing Cultural Safety In Mental Health To Aboriginal Patients: A Grounded Theory Study*, *International journal of mental health nursing*, vol. 27, no. 1, pp. 204–213.

Mcgregor, J & Hoban, D 2015, *Recovery Colleges International Community Of Practice Proceedings Of June 2015 Meeting*, June 2015.

McGregor, J, Repper, J, & Brown, H 2014, “The College Is So Different From Anything I Have Done”. A Study Of The Characteristics Of Nottingham Recovery College, *The Journal of Mental Health Training, Education and Practice*, vol. 9, no. 1, pp. 3–15.

Meddings, S, Byrne, D, Barnicoat, S, Campbell, E, & Locks, L 2014, *Co-delivered And Co-produced: Creating A Recovery College In Partnership*, *The Journal of Mental Health Training, Education and Practice*, vol. 9, no. 1, pp. 16–25.

Meddings, S, Campbell, E, Guglietti, S, Lambe, H, Locks, L, Byrne, D, & Whittington, A 2015, *From Service User To Student: The Benefits Of Recovery College*, *Clinical Psychology Forum*, vol. 2015, no. 268, pp. 32–37.

Meddings, S, Guglietti, S, Lambe, H, & Byrne, D 2014, *Student Perspectives: Recovery College Experience*, *Mental Health and Social Inclusion*, vol. 18, no. 3, pp. 142–150.

Meddings, S, McGregor, J, Roeg, W, & Shepherd, G 2015, *Recovery Colleges: Quality And Outcomes*, *Mental Health and Social Inclusion*, vol. 19, no. 4, pp. 212–221.

Mental Health Commission of NSW 2014, *Learning For Recovery*, viewed 23 January 2018, <<https://nswmentalhealthcommission.com.au/news/commission-news/learning-for-recovery>>.

Mental health community coalition ACT Inc. 2017, *Recovery College Project Report To Stakeholders On Co-Design Workshops*.

Mind 2018, *Mind Recovery College 2018 Course Guide Victoria And South Australia*.

Mind Australia 2012, *Establishment Of The Mind Recovery College: A Concept Paper*, Heidelberg: Mind Australia.

Morgan, P 2017, *Recovery Colleges – Bridging The Gap In Mental Health Service Provision*, *Mental Health Today*, viewed 23 January 2018, <<https://www.mentalhealthtoday.co.uk/recovery-colleges-bridging-the-gap-in-mental-health-service-provision>>.

Naylor, C, Taggart, H, & Charles, A 2017, *Mental Health And New Models Of Care*, The Kings' Fund, London.

Newman-Taylor, K, Stone, N, Valentine, P, Sault, K, & Hooks, Z 2016, *The Recovery College: A Unique Service Approach And Qualitative Evaluation*, *Psychiatric Rehabilitation Journal*, vol. 39, no. 2, pp. 187–190.

Nunley, A & Stott, S 2016, *ALA Forum 2016 Community Based Adult Learning , Health And Wellbeing At A*

## Appendix A. Cited references

---

Recovery College.

Oh, H & DeVyllder J 2013, *The Pedagogy Of Recovery Colleges: Clarifying Theory*, *Mental Health Review Journal*, vol. 18, no. 4.

One Door Mental Health 2018, *Working Together – Western Sydney Recovery College*, viewed 6 March 2018, <<http://wsydrecoverycollege.org.au/program-course/working-together/>>.

Perkins, AM, Ridler, JH, Hammond, L, Davies, S, & Hackmann, C 2017, *Impacts Of Attending Recovery Colleges On NHS Staff, Mental Health and Social Inclusion*, vol. 21, no. 1, pp. 18–24.

Perkins, R, Repper, J, Rinaldi, M, & Brown, H 2012, *Recovery Colleges, ImROC Briefing Paper 1*.

Perkins, R, Repper, J, Rinaldi, M, & Brown, H 2014, 1 . *Recovery Colleges, Kroonika*, vol. 11, no. 2, pp. 1–12.

Perkins, R, Meddings, S, Williams, S, & Repper, J 2018, *Recovery Colleges 10 Years On*, Nottingham, ImROC.

Perkins, R & Slade, M 2012, *Recovery In England: Transforming Statutory Services?*, *International Review of Psychiatry*, vol. 24, no. 1, pp. 29-39.

Perth South PHN 2017, *Perth South PHN Core Needs Assessment 2.0*, Perth. Viewed 1 March 2018, <[http://www.wapha.org.au/wp-content/uploads/2018/02/180228\\_PHN\\_NeedsAssessment\\_Core\\_PerthSouth\\_v2\\_ForPublication.pdf](http://www.wapha.org.au/wp-content/uploads/2018/02/180228_PHN_NeedsAssessment_Core_PerthSouth_v2_ForPublication.pdf)>

Psychiatric Disability Services of Victoria 2016, *Towards Recovery - Hope, Innovation And Co-Design*.

Repper, J n.d., *Recovery Colleges: Where They Came From, How They Work And Whether They Make A Difference*.

Repper, J 2013, *The Transformatory Power Of A Recovery College*, Nottinghamshire Healthcare.

Rinaldi, M, Marland, M, & Wybourn, S 2012, *Annual Report 2011 – 2012 South West London Recovery College, London: Mental-health NHS Trust*, pp. 1–15.

Rinaldi, M, Marland, M, & Wybourn, S 2012, *South West London Recovery College Annual Report 2011-2012*, no. August, p. 15.

Rinaldi, M & Wybourn, S 2011, *The Recovery College Pilot In Merton And Sutton: Longer Term Individual And Service Level Outcomes*, SW London and St Georges NHS Trust, London.

Roberts, G & Boardman, J 2014, *Becoming A Recovery-oriented Practitioner*, *Advances in Psychiatric Treatment*, vol. 20, no. 1, pp. 37–47.

Schrank, B & Amering, M 2017, *Recovery In Mental Health: Global Perspectives*, *Journal of Recovery in Mental Health*, vol. 1, no. 1.

Secker, J 2014, *Evaluation Of The Mid Essex Recovery College January–April 2014*, [arro.anglia.ac.uk](http://arro.anglia.ac.uk).

Secker, J & Wilson, C 2014, *Evaluation Of The Mid Essex Recovery College, October–December 2013.*, [arro.anglia.ac.uk](http://arro.anglia.ac.uk).

Shepherd, G, Boardman, J, Rinaldi, M, & Roberts, G 2014, *Supporting Recovery In Mental Health Services: Quality And Outcomes*, *Centre for Mental Health*, no. 3, pp. 1–34.

## Appendix A. Cited references

---

- Skinner, S & Bailey, A 2015, *CNWL Recovery And Wellbeing College: Annual Report April 2014-July 2015*, Central North West London NHS Foundation Trust.
- Slade, M, Mcdaid, D, Shepherd, G, Williams, S, & Repper, J 2017, 4. *Recovery: The Business Case*, eprints.nottingham.ac.uk.
- Smith-Merry, J, Mellifont, D, Gillespie, J, & Salvador-carulla, L 2016, *Recovery-oriented Mental Health Models*.
- Social Ventures Australia 2017, *The Value Of A Peer Operated Service*.
- Sommer, J, Gill, K, & Stein-Parbury, J 2017, *Walking Side-by-side: Recovery Colleges Revolutionising Mental Health Care, Mental Health and Social Inclusion*, vol. 22, no. 1, pp. 18–26.
- South Eastern Sydney Local Health District NSW 2014, *EOI Mental Health Recovery College, South Eastern Sydney Local Health District*.
- South Eastern Sydney Recovery College 2018, *South Eastern Sydney RC 2018 Term 1 Course Guide*.
- South West London and St George's Mental Health NHS Trust 2011, *South West London Recovery College*, pp. 1–22.
- St Mungo's Registered Charity 2018, *Recovery College - St Mungo's*, viewed 27 February 2018, <<https://www.mungos.org/our-services/recovery-college/>>.
- Stein-Parbury, MJ & Gill, K 2014, *A College For Recovery? Co-production In Action, Symposium of the Sydney Alliance for Healthcare Research and Teaching, Sydney 2014*.
- Sutton, D 2015, *Talking Point: The New Mindset On Mental Health*.
- Taggart, H & Kempton, J 2015, *The Route To Employment: The Role Of Mental Health Recovery Colleges*.
- The Recovery College Camden and Islington 2016, *The Recovery College Course Guide Spring 2016*.
- Thornhill, H & Dutta, A 2016, *Are Recovery Colleges Socially Acceptable?*, *BJPsych International*, vol. 13, no. 1, pp. 6–7.
- Torre, D, Groce, V, Gunderman, R, Kanter, J, Durning, S, & Kanter, S 2017, *Freire's View Of A Progressive And Humanistic Education: Implications For Medical Education*, *MedEdPublish*, vol. 6.
- Trindall, M & Stott, S 2017, *Working In Partnership: South Eastern Sydney Recovery College*.
- Watts, M, Downes, C, & Higgins, A 2014, *Building Capacity In Mental Health Services To Support Recovery. An Exploration Of Stakeholder Perspectives Pre And Post Intervention*, pp. 1–90.
- Watts, M, Downes, C, & Higgins, A 2014, *Building Capacity In Mental Health Services To Support Recovery . An Exploration Of Stakeholder Perspectives Pre And Post Intervention*, Dublin.
- Wels, J 2016, *An Evaluation Of The Greenwich Recovery College*.
- Williams, S 2016, *Addressing Inclusion: Developing An Innovative Technology Assisted Learning Package For Educators And Students For Use In A UK Recovery College*, bradscholars.brad.ac.uk.
- Windsor, L, Roberts, G, & Dieppe, P 2017, *Recovery Colleges – Safe, Stimulating And Empowering.*, *Mental Health & Social Inclusion*, vol. 21, no. 5, pp. 280–288.

## Appendix A. Cited references

---

Zabel, E, Donegan, G, Lawrence, K, & French, P 2016, *Exploring The Impact Of The Recovery Academy: A Qualitative Study Of Recovery College Experiences*, *The Journal of Mental Health Training, Education and Practice*, vol. 11, no. 3, pp. 162–171.

Zucchelli, FA & Skinner, S 2013, *Central And North West London NHS Foundation Trust's (CNWL) Recovery College: The Story So Far...*, *Mental Health and Social Inclusion*, vol. 17, no. 4, pp. 183-189.