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Review Article

Recovery Colleges in the UK and Australia—How Do They Compare? A Scoping Review

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Recovery Colleges are still a relatively new form of mental health service in Australia. This review aimed to explore the current literature on Australian Recovery Colleges and compare this to information on the United Kingdom of Great Britain and Northern Ireland Recovery Colleges. This study followed the Joanna Briggs Institute scoping review guidelines. We searched PubMed, PsycINFO, Web of Science and Scopus for peer-reviewed articles. Grey literature was identified through a four-stage process. All types of literature in English were included with no restriction on publication date. The review included 54 Recovery College studies: 16 Australian and 38 UK. A lack of information on around half of the Australian Recovery Colleges made comparison with UK Colleges and adherence to the core characteristics of the model more uncertain than expected. However, information extracted about the Recovery College characteristics and outcomes was similar for both Australian and UK Colleges. Co-production, which values diverse experience, expertise or knowledge in an equal relationship, is a critical component in the implementation of Recovery Colleges. However, there were knowledge gaps in the role of co-production in College governance and everyday operation. The review also supports the importance of recovery orientation and the value of being an educational service providing co-learning, which is essential to challenging the attitudes, eroding the traditional power relationships and imparting real-life examples of the challenges and realities that people face in their recovery journeys. Further research on Australian Colleges is required to better understand their implementation and outcomes.

Keywords: co-production; lived experience of mental health issues; personal recovery

1. Introduction

Recovery-focussed education's appearance in Australia is comparatively recent, although this model has been used for nearly 3 decades in the United Kingdom of Great Britain and Northern Ireland (UK). Recovery Colleges are still a relatively new alternative model of care and support in Australia. They provide recovery-focussed education based on co-production to build a collaborative, inclusive learning environment, fostering hope and autonomy, recognising the expertise of everyone involved which enables the learning of skills at the same time assists people to realise their own

abilities and strengths [1]. Personal recovery has been described as a person taking control of their own life and mental health to live the life they want to live [2]. Recovery Colleges are designed to complement other services and assist in helping people stay well, build a meaningful life and reduce the incidence and severity of relapse [3]. The first Recovery College was funded for a 12-month trial in South West London, United Kingdom (UK), in 2009 [4]. Since this trial, Recovery Colleges have spread rapidly. The UK has now established over 80 Colleges and more than 20 different countries have established Recovery Colleges, including Australia, Canada, Hong Kong, the Republic of Ireland and Germany [5, 6].

The co-production principle is a core characteristic of Recovery Colleges [1]. The co-production principle outlines the equal partnership between the expertise of people with lived experience of mental health issues and those with subject matter or professional expertise. The use of co-production means that people with lived experience have input into all aspects of the Colleges, including how they function, what courses are held and where and how they are delivered. This is considered to be the critical element of Recovery Colleges as it creates a new way of working that is not traditional or tokenistic, can lead to power structure changes and demonstrates the importance of lived and professional experience contributing equally to all aspects of the College to provide a safe and enabling environment [1, 7, 8]. It demonstrates to students that people with lived experience can develop and grow, and opens up opportunities for students to explore what is possible in their own lives [1, 7].

The first Recovery Colleges in the UK commenced in Southwest London and Nottingham in 2011. These were innovative services that aimed to change the focus of mental health services from symptom reduction to helping people live a valued life. They operated under eight defining features including the co-production principle which Perkins et al. outlined in 2012 [3]. These were refined and simplified in 2018 [1] to five core characteristics, which are that Recovery Colleges: (1) use a co-production model; (2) use recovery and educational principles; (3) are strengths-based and person-centred; (4) are open to all with an interest in mental health; and finally (5) are progressive, giving people choice and control of their learning and assisting them to reach their own goals.

1.1. Contextual Differences in Healthcare Systems. The most widely endorsed Recovery College model was developed and evaluated in the UK, an industrialised country with similar mental health policies to Australia. However, the UK and Australia have vastly different geography, population density, and government and health systems, which may impact the way Recovery Colleges develop and operate, and their impacts on students, staff and health professionals. The UK has 68 million people, a geographical area of just over 240 thousand square kilometres and a population density of 282 people per square kilometre. Australia is a country of 26 million people, a geographical area of over 7.5 million square kilometres and a population density of 3 people per square kilometre [9]. Even considering the large areas of Australia that are not inhabited, the population density in certain areas of Australia is dramatically low compared to the UK; 50 people per square kilometre in the most rural areas of the UK [10] to less than 0.1 people per square kilometre in Australia [11]. The vast distances needed to travel in Australia also affect the accessibility of metropolitan, rural and remote in-person delivered services.

The UK has a universal health care system, including mental health, which is funded through the UK Government. It provides free health care (with the exception of dental, optical and prescription medicines in England) to all UK citizens [12]. The majority of Recovery Colleges in the UK are funded by this national system, and others are funded in partnerships through this scheme and charity organisations [13]. Australia also has a universal healthcare system, Medicare, which supplies free hospital care for all Australians. However, funding for mental health care, which comes from all levels of government, private and charity organisations and individuals, is more complex. The Australian Government funds, through Medicare, GPs, psychiatrists and allied health professionals for primary mental health care. They pay the scheduled fee for a GP visit and 85% for specialist visits; however, the scheduled fee is not compulsory, and many health professionals charge greater amounts, requiring a greater amount to be funded out-of-pocket by the individual. The Australian Government also funds veteran mental health services through the Department of Veterans' Affairs and psychosocial support programs for people with mental health issues, which are channelled through 31 Primary Health Networks. Primary Health Networks are organisations that are funded by the Australian Government to accomplish two key goals: improving health services particularly for people at risk of poor outcomes and the coordination of health services to increase access for people [14, 15]. As such, funding for Recovery Colleges in Australia is also complex and varied. Funding for Recovery Colleges in Australia can be from State and local area Health Departments, State Mental Health Commissions, educational institutions and through community organisations.

Since 1992, the Australian Government with the aid of the State and Territory Health Ministers has developed six National Mental Health Plans. The most recent *was Prevention, Compassion, Care: National Mental Health and Suicide Prevention Plan*, released in 2021. These plans are supported by a variety of State and Territory mental health acts, policies and care plans. Despite the national plans, each state or territory decides how and what is funded for mental health. Generally, State and Territory Governments directly fund acute, subacute and residential services, and they also fund community organisations to provide support and rehabilitation services for people with a psychiatric disability. Where Recovery Colleges fit within this system is still unclear, with the existing Colleges currently funded from a variety of sources mentioned above. Australians with a disability arising from a mental health issue may also be eligible for an individually funded package of support

through the National Disability Insurance Scheme which is jointly funded by the Australian and State and Territory Governments. There are also mental health services that are funded through homelessness support services, charities, nongovernment grants and from individuals' private healthcare funds [16–18].

This review sought to explore whether these contextual differences between the UK and Australia have impacts on how Colleges develop and operate in Australia and whether this affects student outcomes.

1.2. Previous Reviews. Six previously published research studies have examined Recovery Colleges globally, including only one in Australia [19], and all using methods such as narrative literature reviews [20–24], which are typically less systematic, subjective and rely on the authors' prior knowledge to produce an overview of the topic [25]. Alternatively, scoping reviews employ an a priori review protocol, which is used to broadly determine the scope and density of available evidence, to identify key concepts and to identify gaps in the research. Moreover, none of these previous reviews provided a separate analysis for each country. To the authors' knowledge, there has been only one previous scoping review [26] and one systematic review [27] conducted on Recovery Colleges. Both of these focussed primarily on the importance of co-production in Colleges, and whilst Jones et al. [26] looked at adherence to a fidelity criteria and definitions for recovery and co-production in a small number of articles, neither review focussed on highlighting key information on the other characteristics of Recovery Colleges or outcomes for participants [27]. The current review sought to fill these research gaps.

The current review focuses on information (peer-reviewed and grey material) about Australian Recovery Colleges, specifically their differences and similarities to UK Recovery Colleges. Examining Recovery Colleges by country enabled the current review to explicitly identify potential differences between Australian and UK Recovery Colleges' development, and implementation and effects on students, educators, staff or community.

1.3. Research Questions. The specific research questions that this review tried to answer are as follows:

1. How do Australian Recovery Colleges develop?
   a. Do they adhere to the five core characteristics of Recovery Colleges [1].
   b. How similar/different are they from each other and from Colleges in the UK.
2. What outcomes do Australian Recovery Colleges produce for their students, educators and staff?
   a. How similar/different are these outcomes from those found from Colleges in the UK.

1.4. Aim. To answer these research questions, the aims of the current scoping review were to:

1. Explore and document the current literature on how Recovery Colleges in Australia and the UK have developed and been implemented.
2. Compare the Australian Recovery Colleges' extracted findings to findings on UK Recovery Colleges.
3. Examine Recovery College outcomes, including the effects of attendance at Recovery Colleges on their students, educators and staff.

2. Method

The scoping review was conducted in accordance with the Joanna Briggs Institute (JBI) methodology for scoping reviews to assess and analyse both the peer-reviewed and grey literature on Australian and UK Recovery Colleges [28]. This review adhered to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses—Extension for Scoping Reviews (PRISMA-ScR) checklist and guidelines [29] (the checklist is available in the supporting information (available here)). The protocol was registered in the Open Science Framework (https://osf.io/h69fm).

2.1. Peer-Reviewed Studies. The lead researcher (DGS) performed searches in PubMed, PsycINFO, Web of Science and Scopus using the search criteria outlined below in Table 1. These criteria were developed through an initial search conducted by the lead researcher in October–November 2021 and in conjunction with library personnel at the Australian National University.

2.2. Grey Literature. To account for the wide range of sources for grey literature, DGS used the following strategies to find potentially relevant reports on Recovery Colleges:

1. Using the same search terms presented in Table 1, customised search strategies were developed and used to search for relevant literature in each of the following search engines: DuckDuckGo, Google Advanced and Google Scholar.
2. Specialised mental health recovery websites, the RECOLLECT Recovery College repository of research and Implementing Recovery through Organisational Change (ImROC) research page were searched for relevant literature.
3. Searching the reference lists of key relevant international reviews that included Australian or UK studies of Recovery Colleges.
4. Consultation with content experts, including the Australian/New Zealand Recovery College Community of Practice.

Searches were conducted between March and April 2022 and were updated again in both January 2023 and November 2023. The initial searches were not restricted by publication date but were restricted to documents published in English. Documents from qualitative studies, mixed-methods studies, quantitative studies, observational studies and narrative reviews were included. Grey literature eligible for inclusion

Table 1: Search strategy for PubMed search.

Terms
"Recovery College*" OR "Recovery Academ*" OR "Recovery Education Cent*" OR "Discovery College*" OR "Discovery Academ*" OR "Discovery Education Cent*" OR "Empowerment College*" OR "Empowerment Academ*" OR "Empowerment Education Cent*" OR "Health and Wellbeing College*" OR "Health and Wellbeing Academ*" OR "Health and Wellbeing Education Cent*"

was conference papers, government reports, theses, dissertations and evaluation reports. However, news, magazine and web blog articles, College prospectus, College seminar/term course schedules, College course outlines and tender documents were not included, as the researchers' prior knowledge of these types of sources was that they were unlikely to include relevant information on Recovery College characteristics or outcomes.

All identified records were downloaded to EndNote 20 Reference Manager (Clarivate Analytics, PA, USA) and imported into Covidence systematic review software (Veritas Health Innovation, Melbourne, Australia). Duplicate citations were removed using Covidence. Titles and abstracts and full-text screening for all the documents found in the first search (March–April 2022, 4172 documents) were performed independently against the inclusion and exclusion criteria (Table 2 below) by the lead (Dianna G. Smith) and one other researcher (Amelia Yazidjoglou, Amelia Gulliver, Terri Warner, Amelia Yazidjoglou). There were few disagreements between the researchers at any of the stages in the review, and any disagreements were discussed and resolved between the two researchers with no need for external adjudication.

NB: For this review:

- Students are anyone who has attended a course at a Recovery College, they can include people with mental health lived experience, anyone caring for a person with mental health lived experience, peer workers, professional or clinical workers or community members who have an interest in mental health.
- Staff are the permanent paid or volunteer workers of a Recovery College.
- Educators are both people with lived experience and people with subject matter experience who develop and/or facilitate courses at a Recovery College.

For pragmatic reasons, the documents identified in the second (January 2023, 193 documents) and third search (November 2023, 125 documents) were screened by the lead researcher (Dianna G. Smith) only for both abstract and full-text review. The reference lists of all materials selected for inclusion in the full-text review were screened for additional studies. These records were then screened by the lead researcher in the full-text review for inclusion.

2.3. Data Extraction. The researchers developed a data extraction tool. This was developed with reference to three articles that were part of the Recovery Colleges Characterisation and Testing (RECOLLECT) Study (researchintorecovery.com/recollect) [20, 23, 24]. The lead (Dianna G. Smith) and one other researcher (Alyssa R. Morse, Amelia Gulliver, Lisa Brophy, Amelia Yazidjoglou) independently extracted into a Microsoft Excel spreadsheet the following data from documents relating to Australian Recovery Colleges (14 documents from the initial and second searches):

- Author and year.
- Location (country).
- Type of literature.
- Study design.
- Study population.
- Recovery College characteristics which included co-production, recovery principles, education principles, strengths-based and person-centred focus, availability to all, and location and distinctiveness of the service.
- Student outcomes which included information on student participation and whether attendance at a Recovery College assisted students in their recovery.
- Service outcomes which included changes to service usage, as well as impacts on services due to interactions with the Colleges.
- Societal outcomes.

The results of the extraction for the Australian documents showed that discrepancies between the reviewers were minor and resulted in clarification of detail needed for extraction. The documents relating to UK Recovery Colleges (34 documents) and all studies included from the third search (6 documents) were extracted by the lead researcher (Dianna G. Smith) only.

2.4. Quality Appraisal of the Evidence. Critical appraisals are not mandatory for scoping reviews; however, reviewers can decide that this is needed as part of the purpose of the review [28]. The researchers decided that as the review will be assessing the similarities and differences between Recovery Colleges' implementation and the effects on the student, staff and community, the quality of the information is relevant and that necessitated an appraisal of the evidence. To do this, Kmet et al. [30] criteria for qualitative and quantitative research to assess the documents were used in the review. The criterion for qualitative research includes 10 items, giving a possible maximum of 20 points. The quantitative assessment has 14 items, with nine items having a not applicable category, giving a maximum score of between 10 and 28 points. These scores are then turned into percentages, and Kmet et al. [30] suggest that the percentages can be used as a cut-off for excluding studies, recommending scores between 55% (liberal) to 75% (conservative) for cut-offs into a systematic review. All articles were assessed at the time of extraction, and any discrepancies were resolved between the two researchers with no need for external adjudication.

Table 2: Inclusion and exclusion criteria.

Inclusion criteria	Exclusion criteria
Any articles on Australian and UK Recovery Colleges	Recovery College information NOT IN Australia and the UK (which includes England, Scotland, Wales and Northern Ireland) Studies that include information from multiple countries that do not analyse the information for each country separately
Information on student, educator or staff outcomes from attending an Australian or UK Recovery College	Information on collegiate recovery programmes or collegiate recovery communities (these are college or university programmes that support students with substance use issues to start and complete their education) Psychoeducational or recovery-oriented courses or programs not run in Recovery Colleges

3. Results

A total of 4490 documents were identified, with 480 duplicates removed before screening. 4010 documents were screened using the title and abstract with 125 documents progressing to full-text screening. At the conclusion of full-text screening, 54 studies were included in the review. Figure 1 presents the reasons for article exclusion at the full-text stage.

Of the 54 documents included in the scoping review, 16 documents were about Australian Recovery Colleges and 38 were about Recovery Colleges in the UK. The Australian documents were published between 2014 and 2023 and the UK documents between 2012 and 2023. Mixed methods were used by 26 studies to gather data; 19 used qualitative methods, 7 used quantitative methods, and 2 documents did not supply any information on how the information was gathered. Forty-four documents (10 Australian and 34 from the UK) were peer-reviewed articles with the remainder (6 Australian and 4 UK) grey material (see Table 3 for information on the type of document).

It is unclear from the available information whether Australian Recovery Colleges develop and are implemented in a similar way to the UK Colleges and if they adhere to the core characteristics outlined by Perkin et al. [1], as the majority of the documents that included information on Recovery College characteristics in both locations did not report on all the characteristics. One notable factor is that the information available about Australian Colleges is limited to only about half of the Colleges (6 Colleges) that were ever established in Australia. However, information extracted from the documents about the Recovery College characteristics and outcomes for students, staff and services are similar for both Australian and UK Colleges, despite the difference between the two countries. The only document found to have investigated societal outcomes came from the UK, so this outcome could not be compared.

3.1. Funding. Funding sources found in the documents differed between the two countries which was expected given the differences around where mental health is situated and funded in Australia and the UK. Just over two-thirds (69%) of the documents (9/16 Australian and 30/38 UK) did not have any information on funding. From the available evidence, Australian Recovery Colleges were funded by State governments [31–36], grants and donations [37, 38], and/or a combination of community organisation and grants [39]. The UK Recovery Colleges are funded from NHS Trust [40–43], lottery and NHS Trust [44], and joint NHS and community organisations [45, 46]. Hayes et al. [13] stated that of the Colleges that responded (63 out of 88 colleges), only 48 supplied information on funding. Of those who reported a single source of funding, just over three-quarters of the UK Recovery Colleges are affiliated with the NHS (Trust or Clinical Commissioning Group). Of the UK Colleges that stated two funding sources, funding was most likely to be from the NHS. For Colleges with three or more funders, the most common source was charities.

3.2. Recovery College Characteristics. Recovery College characteristics reported in each document are presented in Table 4. The majority of Australian documents (94%) and half (50%) of the UK documents reported on at least one of the extracted Recovery College characteristics. Only three (one Australian [31] and two UK [3, 13]) documents mentioned all the extracted Recovery College characteristics. The information from both the Australian and UK documents described similar findings for the characteristics they reported. A notable difference found was that a few UK colleges mentioned a different form of Recovery College, a pop-up College/campus of a College, which is not reported in any Australian Recovery College documents.

Co-production was the most reported characteristic with the majority of documents from both Australia and the UK mentioning the co-production and cofacilitation of courses; some noted the importance of the equal partnership of lived and subject matter experience [3, 34, 47, 58, 67]. Information on the *educational principles* characteristic included educational settings for the facilitation of courses [35, 36, 41, 57], valuing the multiple perspectives that challenged traditional modes of learning [34, 50, 54, 58, 69, 76] and being a safe environment [31, 39, 65]. Recovery Colleges were considered to be different to other educational institutions in that they highlight the use and value of 360° learning [67, 69].

Adherence to *recovery principles* was shown in several different ways including Colleges being a stepping stone to further education, employment and social inclusion [31, 33, 37, 41, 75] and the emphasis of recovery in the courses [47, 57, 77]. The *strengths-based and person-centred* characteristic was only reported in nine documents (5 Australian), information included Colleges allowing student to make their own choices [3, 51, 69], focussing on who they want to be [35, 67] and identifying their own strengths [31, 39, 51]. Whether Colleges were *open to all* was reported in 15 documents (8 Australian), and the *distinctiveness of Colleges* was reported in 11 documents (6 Australian).

3.3. Recovery College Participation Outcomes. Outcomes for students are presented in Table 5 and for staff including educators, and services are presented in Table 6 below. As with the findings about the Recovery College characteristics, the outcomes experienced by students, educators and services were similar for both countries. Only one article from the UK reported on societal outcomes. Crowther et al. [20] reported in their article that increasing the information on mental health and people with mental health issues led to more social inclusion of people with mental health issues. Community organisations also benefited from working with Recovery Colleges through 'increased public access to their services and increased co-production in their own work' [20].

3.4. Student Outcomes. There is no clear picture of the students who attend Recovery Colleges with only three articles (1 Australian) [4, 31, 68] having detailed information on student characteristics including gender, age, ethnicity, type of student, e.g., lived experience, professional or

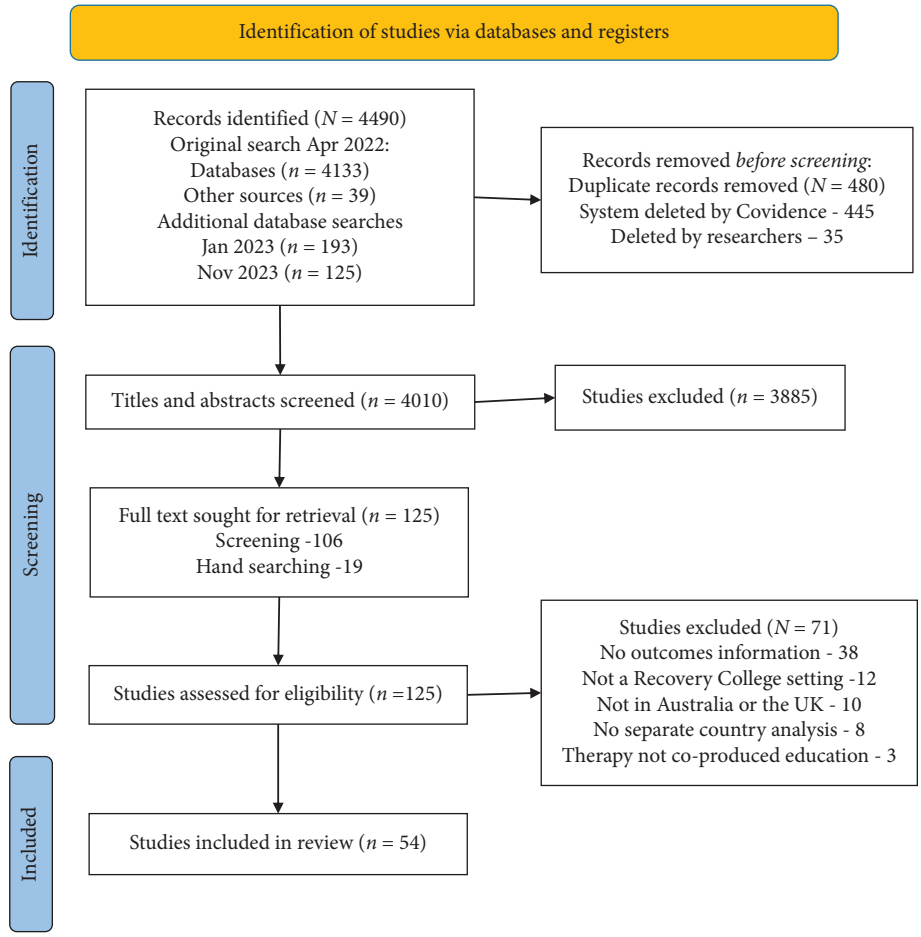

Figure 1: PRISMA flowchart of the study selection process.

support people. Brophy et al. [31] also included information on LGBTQIA+, primary language, employment status, educational level, learning and other support needs, and Rinaldi et al. [4] on diagnosis and mean number of years in contact with mental health services. A further seven included some basic information, gender [13, 49], age [5, 13], type of student [5, 37, 56], geographic area [20] or Indigenous status [53].

Student participation in Recovery Colleges and service-use implications of that participation was reported in 11 documents, 4 from Australia and 7 from the UK. These documents report a number of courses and terms students attended the College [4, 32, 36], a number of courses completed [31, 36, 55], and the reasons for attending or not attending courses [61, 63]. More importantly, decreases in mental health service use including hospital stays and emergency department visits [32, 34, 43, 56, 62] were also identified.

How attendance at Recovery Colleges assists students in their recovery was reported in 31 documents (12 Australian and 19 from the UK). Students reported benefiting from: realising that they are not alone [35, 62]; the social interaction and connections with others [31, 35, 39, 42, 46, 53, 68]; feeling hope for the future and sense of purpose [4, 31, 34, 35, 37, 40, 41, 53, 62]; and normalised mental ill health and reduction of stigma including self-stigma [53, 62, 70, 72]. They emphasised better mental health and increased wellbeing [34, 46, 63, 68, 73, 75], and better physical health and healthier lifestyles [21, 34, 39, 47]. They mentioned enjoying the safe environment [47, 49, 66, 71, 72]; acquisition of new knowledge and skills [31, 37, 38, 44, 49, 65, 73, 74]; and the ability to make their own decision and choices on which courses to pursue [32, 41]. The students also reported on increased employment opportunities [34, 41, 43, 47], improved attitude to education [49] and commitment to and achievement of goals [4, 35, 36, 39, 57, 62, 68].

3.5. Staff Including Educators' Outcomes. Staff outcomes were reported in 14 documents, an equal number from each country under study. Staff and educators reported changes to practices [20, 35, 59, 74, 78]; personal changes including increasing confidence [20, 39, 42, 74]; changing views of recovery, looking at things in a different way [34, 35, 37, 47, 72]; co-production and changing perceptions of lived experience [37, 38, 59, 60]; staff wellbeing [20, 74]; and the lived experience benefits of becoming an educator [31, 37, 38, 59]. One factor that was only mentioned by Australian documents was the importance of managerial

Table 3: Characteristics of included documents.

Author/year	Study design	Type of literature	Recovery college/s	Number of participants	Quality assessment	
					Quant	Qual
Australian						
Cronin et al. [32]	Quantitative	Peer-reviewed article	South Eastern Sydney Recovery and Wellbeing College	184	95% (19/20)	
Doroud et al. [33]	Mixed methods	Peer-reviewed article	ACT Recovery College	82	94% (15/16)	95% (19/20)
Hall et al. [47]	Mixed methods	Peer-reviewed article	Mind Recovery College	51	56% (9/16)	70% (14/20)
Hopkins et al. [38]	Mixed methods	Peer-reviewed article	Discovery College expansion	42	25% (5/20)	30% (6/20)
Hopkins et al. [48]	Qualitative	Peer-reviewed article	Discovery College	12		30% (6/20)
Hopkins et al. [49]	Mixed methods	Peer-reviewed article	Discovery College	65 pre-course, 46 post-course.	72% (13/18)	45% (9/20)
Muir-Cochrane et al. [34]	Qualitative	Peer-reviewed article	Southern Adelaide Local Health Network Recovery College	22		85% (17/20)
Sommer et al. [35]	Qualitative	Peer-reviewed article	South Eastern Sydney Recovery and Wellbeing College	29		85% (17/20)
Sommer et al. [36]	Quantitative	Peer-reviewed article	South Eastern Sydney Recovery and Wellbeing College	64	59% (13/22)	
Whitehead et al. [50]	Mixed methods	Peer-reviewed article	Discovery College	522 over 5 yrs	80% (8/10)	80% (16/20)
Brophy et al. [31]	Mixed methods	Grey literature	ACT Recovery College	82	95% (19/20)	85% (17/20)
Gill [37]	Mixed methods	Grey literature	South Eastern Sydney Recovery and Wellbeing College	Unclear	35% (7/20)	45% (9/20)
Hall et al. [39]	Mixed methods	Grey literature	Mind Recovery College	54	50% (9/18)	55% (11/20)
Hardy [51]	No information	Grey literature	Mind Recovery College	No information	0/20	0/18
Hardy [52]	No information	Grey literature	Mind Recovery College	No information	0/20	0/20
Trindall & Stott [53]	Mixed methods	Grey literature	South Eastern Sydney Recovery and Wellbeing College	No information	40% (8/20)	40% (8/20)
United Kingdom of Great Britain and Northern Ireland						
Ali et al. [54]	Qualitative	Peer-reviewed article	West Midlands Recovery College	25		100% (20/20)
Bourne et al. [55]	Quantitative	Peer-reviewed article	Sussex Recovery College	463 students. 11,543 service users	85% (19/20)	
Bowness et al. [56]	Quantitative	Peer-reviewed article	3 colleges—Leicester, South London and Maudsley (SLaM), and Sussex Recovery Colleges	2654	95% (21/22)	

Table 3: Continued.

Author/year	Study design	Type of literature	Recovery college/s	Number of participants	Quality assessment	
					Quant	Qual
Burhouse et al. [57]	Mixed Methods	Peer-reviewed article	"Pop-up" Recovery Colleges Gloucestershire/ Herefordshire	50	30% (6/18)	65% (13/20)
Cameron et al. [58]	Qualitative	Peer-reviewed article	Unclear	13		80% (16/20)
Crowther et al. [20]	Qualitative	Peer-reviewed article	South London and Maudsley, Leicestershire and Sussex	33		85% (17/20)
Dalgarno and Oates [59]	Qualitative	Peer-reviewed article	Recovery College, South, England	9		75% (15/20)
Dalgarno and Oates [60]	Qualitative	Peer-reviewed article	Recovery College, South, England	8		75% (15/20)
Dunn et al. [61]	Mixed methods	Peer-reviewed article	Unclear	16	67% (8/12)	75% (15/20)
Ebrahim et al. [62]	Mixed methods	Peer-reviewed article	Recovery College, Northern England	56	94% (15/16)	80% (16/20)
Frayn et al. [40]	Qualitative	Peer-reviewed article	Langdon Hospital	8		45% (9/20)
Harper and McKeown [63]	Qualitative	Peer-reviewed article	Recovery College, Northwest England	4		75% (15/20)
Hayes et al. [13]	Quantitative	Peer-reviewed article	63 colleges around the UK	63 colleges	100% (18/ 18)	
Kay and Edgely [41]	Mixed methods	Peer-reviewed article	Health and Wellbeing College, Pennine Care NHS Foundation Trust	No information	36% (5/14)	30% (6/20)
King et al. [64]	Qualitative	Peer-reviewed article	Unclear	No information		60% (12/20)
Lane [65]	Qualitative	Peer-reviewed article	Unclear	309		80% (16/20)
Martina [66]	Mixed methods	Peer-reviewed article	Sussex Recovery College	8	83% (10/12)	70% (14/20)
McGregor et al. [67]	Mixed methods	Peer-reviewed article	Nottingham Recovery College	no information	36% (5/14)	40% (8/20)
Meddings et al. [68]	Mixed methods	Peer-reviewed article	Unclear	35.	75% (12/16)	70% (14/20)
Meddings, Byrne et al. [45]	Mixed methods	Peer-reviewed article	Hastings Recovery College	no information	50% (6/12)	45% (9/20)
Meddings et al. [69]	Qualitative	Peer-reviewed article	Sussex Recovery College	41		85% (17/20)
Newman-Taylor et al. [42]	Qualitative	Peer-reviewed article	Recovery College in the South, England.	11		55% (11/20)
Nurser et al. [70]	Mixed methods	Peer-reviewed article	Recovery College East	58	69% (11/16)	50% (10/20)
Nurser et al. [71]	Qualitative	Peer-reviewed article	Recovery College East	8		90% (18/20)

Table 3: Continued.

Author/year	Study design	Type of literature	Recovery college/s	Number of participants	Quality assessment	
					Quant	Qual
Perkins et al. [72]	Mixed methods	Peer-reviewed article	Unclear	94	71% (10/14)	80% (16/20)
Rocca et al. [73]	Quantitative	Peer-reviewed article	Unclear	68	100% (20/20)	
Stevens et al. [74]	Mixed methods	Peer-reviewed article	Sussex Recovery College	57 at T0, 20 at T2 and 19 at T3	89% (16/18)	80% (16/20)
Sutton et al. [43]	Quantitative	Peer-reviewed article	Recovery, Health and Wellbeing Academy, Greater Manchester	108 at T0, 53 at T2.	91% (20/22)	
Thompson et al. [75]	Qualitative	Peer-reviewed article	Sussex Recovery College	14		90% (18/20)
West et al. [76]	Qualitative	Peer-reviewed article	Unclear	4		80% (16/20)
Wilson et al. [46]	Mixed methods	Peer-reviewed article	South East Essex Recovery College	101 at T0, 11 at T2, 42 at T3. 17 in focus groups	94% (17/18)	80% (16/20)
Wolverson et al. [77]	Mixed methods	Peer-reviewed article	Multiple Recovery Colleges	261 responses	80% (8/10)	75% (15/20)
Yoeli et al. [44]	Mixed methods	Peer-reviewed article	Recovery in Mind (RiM), West Berkshire, England,	89 at T0, 71 at T1, 44 at T2 and 18 at T3, 6 interviews	88% (14/16)	75% (15/20)
Zabel et al. [78]	Qualitative	Peer-reviewed article	The Recovery Academy, Greater Manchester	21		80% (16/20)
Anfossi [5]	Mixed methods	Grey literature	39 colleges around the UK	39 colleges	100% (10/10)	85% (17/20)
Cameron et al. [79]	Mixed methods	Grey literature	Sussex Recovery College	73	0% (0/10)	40% (8/20)
Perkins et al. [3]	Qualitative	Grey literature	Unclear, Southwest London and Nottingham Recovery Colleges mentioned	No information		25% (5/20)
Rinaldi et al. [4]	Mixed methods	Grey literature	Southwest London Recovery College	no information	50% (9/18)	45% (9/20)

Table 4: Recovery college characteristics.

Author/year	Co-production	Education principles	Recovery principles	Strengths-based and person-centred	Available to all	Distinctiveness
Australian						
Doroud et al. [33]	NR	NR	A stepping stone that supported recovery, growth and inclusion	NR	NR	College was a unique and innovative space
Hall et al. [47]	Changes to their practice for reviewing courses and on the equal partnership of lived and subject matter staff	Structure is that of an educational facility	Student encouraged to look for different options, emphasis on recovery in courses and the interaction between staff, educators and students	NR	NR	NR
Hopkins et al. [38]	College coproduces courses and maintains co-production is used in all aspects of the college	NR	NR	NR	NR	NR
Hopkins et al. [48]	Establishment of the committee and the co-production of courses	NR	Themes of the research show commitment to recovery	NR	NR	NR
Hopkins et al. [49]	NR	NR	NR	NR	NR	Focus is on younger people
Muir-Cochrane et al. [34]	Courses co-produced, cofacilitated and the importance of peer educators	Pedagogical approach described focuses on learning through experience. Collaborative and shared learning process	Normalising mental illness, student listened to, and input valued, commitment of staff to improving student lives	NR	Referrals from mental health professionals as well as self-referral	College was in a tertiary education campus
Sommer et al. [35]	Courses are co-produced, cofacilitated and the audience is a mix of lived and professional experience	Offers courses in partnership with local community colleges	Recovery principles introduced as fundamental to the purpose of RC	Emphasis on goals, development and achievement	NR	NR
Sommer et al. [36]	Courses co-produced and peers lead the learning plan interviews	Courses offered in a number of locations, in partnership with adult education community centres	Goal setting and supporting personally meaningful goal achievement through student learning plans conceptualised as an effective way to support recovery	NR	Restricted to people who live in the area	Courses offered in a number of locations, in partnership with adult education community centres
Whitehead et al. [50]	NR	Course learning goals seen to have been met to a high degree. Valued multiple perspectives that challenged traditional modes of learning	Lived experience positively received as they assisted participants in integrating knowledge	NR	NR	Courses different to traditional mental health information

Table 4: Continued.

Author/year	Co-production	Education principles	Recovery principles	Strengths-based and person-centred	Available to all	Distinctiveness
Brophy et al. [31]	Evidence of co-production in the involvement of lived experience in all levels of the college, lack of resources and the lack of professional/clinical expertise was seen as an inhibitor of co-production	A safe learning environment that offered a space to learn and grow, where educators and students learnt from each other and where students were able to control how they participated	Ability to break down the power imbalance and the capacity for accommodating the transitions from students to educators, having an open policy to enrolment and the high percentage of lived experience in the staff and educators	Safe environment allowed people to discover their own strengths, confidence in their own abilities and that their experiences were valuable	18 +years. Open hours and location, a barrier. Online courses during COVID, a barrier due to a lack of technical knowledge and resources to get online	College was different to other services and filled a gap in ACT mental health services
Gill [37]	Co-production was considered vital to all aspects of the College	Conversion of traditional treatment into learning opportunities	Appreciation of the positive outlook on recovery and acquiring skills to aid recovery	Strength-based approach was appreciated	Service users in the area are able to attend without fees	NR
Hall et al. [39]	Most of the information is about co-production of the evaluation, but co-production is stated in their aims	Educational premise through staffing structure, the safe environment and the use of language, having the access to people with expertise assisting students with knowledge and different perspectives	Provides recovery-oriented education, instilling hope for recovery and imparting recovery information and support, instilling hope by giving value on lived experience and the ability to assist others	Students are treated as whole people, not diagnosis, the environment was empowering, concentrated on skills, sharing of information	There were plans to initiate fees which students would use their individual NDIS funding packages to pay	NR
Hardy [51]	Provides a diagram of the theory of change underpinning their co-production model	An educational service, staff as learning/development consultants. Individual learning plans developed	Lived experience is used to provide new knowledge. College introduces a unique way for people to gain knowledge and understanding	Focus on strengths and assisting people to identify and build on their strengths	Open to all	NR
Hardy [52]	Co-production is only discussed in the context of course development and course facilitation	NR	The value of learning on recovery	NR	Open to all	NR
Trindall & Stott [53]	Course development processes described	NR	Objectives included personal recovery, service transformation, capacity building and employment	NR	Courses are only free to people in the area or staff of participating orgs	NR

Table 4: Continued.

Author/year	Co-production	Education principles	Recovery principles	Strengths-based and person-centred	Available to all	Distinctiveness
United Kingdom of Great Britain and Northern Ireland						
Ali et al. [54]	Staff found difficult to adjust to co-production whilst having benefits for service users	Issue of therapeutic versus educational. Differing definitions of both words	Having a shared and accepted definition of recovery is essential	NR	NR	NR
Burhouse et al. [57]	Information on the design of the courses and feedback gained from students on the courses	Development of the courses, their links with adult education organisations, pathways to form education, more thought needed to accommodate different literacy levels	Development of the courses and the college, the introduction of the coaching sessions and the day long Recovery days. The development of a college pop-up for younger people	NR	NR	Pop-up college
Cameron et al. [58]	Co-production of courses, the incorporation of an academic and the differences that could bring to Recovery Colleges	Benefits of different sites, the less clinical atmosphere, reinforcing the change to student from client/patient, the different methods used, the use of homework to facilitate discussion	Changes to students' confidence and empowerment	NR	NR	NR
Frayn et al. [40]	NR	NR	NR	NR	NR	The College is in a secure setting. It is only open to service users, carers and staff
Hayes et al. [13]	64% of the colleges that responded rated their colleges as high on co-production with another 30% rating their college as medium. They also reported that there were differing interpretations of co-production	48% of colleges that responded rated their colleges as high on adult learning with the same percentage rating their college as medium	70% of the colleges that responded rated their commitment to recovery as high with a further 27% rating as medium	51% of colleges that responded reported their college high on tailored to the student and 49% reported as medium. 79% reported that their college is explicitly strengths-based	30% of colleges that responded said that their colleges were open to specific groups	56% colleges reported that they were mixed location, 48% meet in community or mixed-use venues, and one college was online only
Kay & Edgely [41]	Adopted a model of equal partnership of experience and expertise, course development is a bottom-up approach with students and key stakeholders meeting and discussing any gaps and areas for development at the end of the terms	Links with local adult education providers and they have partnerships with community organisations to develop courses that enhance the students' community, social and practical living knowledge	Links with local adult education providers and that they have established an employment pathway for 20 people	NR	Mentions in year one that 57% of their students were service users and the rest come from carers, staff and the general population	They have two pop-up campus sites and a further campus in the Rehab and high support directorate for people who are unable to leave the wards

Table 4: Continued.

Author/year	Co-production	Education principles	Recovery principles	Strengths-based and person-centred	Available to all	Distinctiveness
King et al. [64]	NR	Recovery College is an educational setting which is different to clinical settings. Does not make any judgements on what is better just suggested that there is room to investigate	NR	NR	NR	NR
Lane [65]	Importance of having experts by experience to facilitate courses	Provision of a safe supportive learning environment	NR	NR	NR	NR
McGregor et al. [67]	Co-production of courses and the growing respect with boundaries between professionals and student more flexible, power relations changing	Choice and control in deciding which courses to attend, control of own learning, active co-learning	Recovery is not one of the domains but is embodied in all domains	College focuses on who you want to become not on what you want to achieve	Open to all service users, carers and families but no mention of open to the general population	NR
Meddings, Byrne et al. [45]	Co-production mentioned, however, peers were employed too late to assist in developing the courses. Groups were convened for various aspects of the development of the model	NR	NR	NR	NR	NR
Meddings et al. [69]	Students valued co-production and Lived Experience trainers	Importance of learning from each other, new knowledge. Suggested themes for improvement were having longer and more courses, solving scheduling conflicts, continuing professional development for trainers and providing more support to attend the college	Students mention having choice is empowering and give hope, also getting help and providing help to other students	One of the themes is choice, students becoming the expert in their own care	NR	NR
Thompson et al. [75]	A subtheme was co-produced, collaborative and learning from each other—co-production is an essential aspect of recovery and equality	A subtheme was co-produced, collaborative and learning from each other, talked about co-learning from each other	An overarching theme was a springboard which included encouraging participants to have hope in the future and opening doors for them to act in their lives	NR	One of the subthemes was inclusive, open and accessible	NR

Table 4: Continued.

Author/year	Co-production	Education principles	Recovery principles	Strengths-based and person-centred	Available to all	Distinctiveness
West et al. [76]	Three themes positive co-production, powerful learning environment and confronting dementia together. All themes came from co-production and working together	Powerful learning environment—open to learning new things and learning from each other	NR	NR	NR	NR
Wolverson et al. [77]	Benefits of co-producing dementia courses including breaking down power structures in traditional relationships and having positive role models	Education is seen as essential for people living with dementia	Recovery in dementia was seen differently; some saw it as living well and maintaining independence, while others did not think recovery applied to dementia	NR	NR	NR
Zabel et al. [78]	The value of co-production included witness journey/ narrative, challenges stigma, breaks down barriers, valuing individual experiences, encourages reflection on the use of language	NR	NR	NR	College open to all	NR
Anfossi [5]	93% of respondents agree with the statement of co-production. They described it as equality, experiences and expertise and course planning	97% agreed that RC operates on college principles. Themes were around educational principles, promotion, being different	100% agreed with the statement that all aspects of the college reflect recovery principles. Celebration, empowerment and peer-centred were the themes	NR	98% agreed inclusion with themes of openness, accessibility and people needs	NR
Cameron et al. [79]	Importance of co-production, quotes from students, tutors on importance of having different viewpoints, experiences and expertise	Importance of having an educational expertise and having alternative venues for conducting courses rather than clinical settings	NR	NR	NR	NR
Perkins et al. [3]	Highlights the need for co-production not just between professional and lived experience but also education experts. Also mentions the need for courses to be co-produced	College needs to be run on college principles, that it is not a day centre or offer treatment or coordination of care. Also mentions the need for a personal tutor that assists the students with their course choice	Language is particularly important and that the messages should be of hope and not deficits based. Mentions the importance of celebrations	People making their own choices and acting on them	Colleges need to be open to all	Differences between colleges and other services

Note: NR = Not reported/unclear from the paper.

Table 5: Student outcomes.

Author/year	Participation outcomes	Recovery outcomes			
		Wellbeing	Health	RC attendance	Future focus
Australian					
Cronin et al. [32]	Number of courses, terms attended, attendance rates, hospital stays, ED visits and community MH contact.	Participants involved in own recovery	NR	NR	NR
Hall et al. [47]	NR	Dissatisfied with the concept of recovery but more accepting of 'discovery'	Positive effects on healthy lifestyles.	Challenging to handle stress from other students; content a trigger; time conflicts	Positive effects on education and employment
Hopkins et al. [38]	NR	NR	NR	Students discussed new things learnt and how they would apply learning	NR
Hopkins et al. [49]	NR	Both young people and adults were positive about their experiences with the college and experienced positive attitude change	NR	NR	In young people, an improved attitude towards education and greater likelihood of participating in future study after completing a course
Muir-Cochrane et al. [34]	Anecdotal evidence of less reliance on medical services	Improvements in hope for the future	Improvements in physical health as well as mental health	NR	Improved engagement in employment and education
Sommer et al. [35]	NR	Hope for the future, connection with other better understanding of recovery	NR	NR	The learning plans give them assistance with their goals
Sommer et al. [36]	Active enrolment time, number of courses confirmed enrolment, number of completed courses and average attendance supplied. Attendance rates, number of courses.	NR	NR	NR	Time spent in the college influences the probability of achieving goals. Employment goals least likely to be achieved. People were harsh raters; they considered changed goals were not achieved rather than changed
Brophy et al. [31]	Course completion, waiting list for courses also mentioned.	Outcomes related to CHIME framework, growth, mood changes	NR	Changes in knowledge, practical techniques, self-reflection	NR
Gill [37]	NR	NR	NR	Students had a better idea of recovery and valued the lived experience accounts	NR
Hall et al. [39]	NR	Impact on social connection, giving them a purpose. Challenges included managing the distress of others, trigger for past pain, difficulties with the word recovery	Impact on adopting a healthy lifestyle,	Impact on picking up or reconnecting with arts and crafts.	Impact on future, commitment to goals

Table 5: Continued.

Author/year	Participation outcomes	Recovery outcomes			
		Wellbeing	Health	RC attendance	Future focus
Hardy [51]	NR	College seen as really different, realising that they are not alone	NR	Students learning more about their mental health and recovery	NR
Trindall & Stott [53]	NR	Themes include breaking down barriers; reducing stigma; empowering; connecting with others; inspiring hope; moving beyond mental illness	NR	NR	NR
UK					
Bowness et al. [56]	Mental health diagnosis for both enrolled and completed was significantly different for two of the Colleges. One college had significantly more inpatient admissions for both groups of students, one college had significantly more admissions for enrolled students, who were more likely to have had Mental Health Act experience	NR	NR	NR	NR
Burhouse et al. [57]	NR	NR	NR	NR	Goal setting and achievement of goals, personal transformation
Bourne et al. [55]	Number of courses completed Reasons for nonattendance were physical illness, personal commitments, relationships with other attendees, psychological wellbeing, distance and time to travel, physical building, prior experience or poor communication with the college. Strategies to improve attendance were travel information, text reminders, attendance needs chats, class size indications, orientation sessions	NR	NR	NR	NR
Dunn et al. [61]		NR	NR	NR	NR

Table 5: Continued.

Author/year	Participation outcomes	Recovery outcomes			
		Wellbeing	Health	RC attendance	Future focus
Ebrahim et al. [62]	Participants reported less GP visits, less need for mental health services which they attributed to Recovery College attendance.	Being seen as individuals, feeling less alone, more hopeful about the future, more positive about recovery, reduction in stigma.	Significant difference for mental wellbeing and on life domains	NR	Achieving goals, inspired to take up volunteering
Frayn et al. [40]	NR	Being less anxious about the future, being able to speak up about issues that are relevant to them and their care	NR	NR	NR
Harper & McKeown [63]	A substantial effort was required to attend the College	Need for socialisation helped motivate.	MH difficulties had effect on learning but despite this most attended and struggled through, attendance had a positive effect on their mental health	Curiosity and wanting to learn helped motivate them to attend the College.	NR
Kay & Edgely [41]	NR	Increases in wellbeing and changes to attitude to self-management and action in own recovery.	NR	NR	Progression to being peer workers in the college
Lane [65]	NR	Changing their thinking on whether recovery is possible, interacting with others.	NR	Learning skills to aid in their recovery	
Martina [66]	NR	Course and the delivery help boost students' confidence	NR	NR	NR
Meddings et al. [68]	NR	Significant difference on, personal recovery, quality of life, significant difference (increase) in number of friends	Significant difference on psychological recovery and mental health and wellbeing and psychological distress scales	Significant difference, course learning outcomes	Significant difference on personal goals. No differences for employment or becoming a student.
Newman-Taylor et al. [42]	NR	Overarching theme of connecting with others differently and three subthemes, reflecting on 'stuckness', quality of relationships enables change	NR	NR	Subtheme on widening horizons

Table 5: Continued.

Author/year	Participation outcomes	Recovery outcomes			
		Wellbeing	Health	RC attendance	Future focus
Nurser et al. [70]	NR	Significant increases in recovery scores and decreases in stigma scores found	NR	NR	NR
Nurser et al. [71]	NR	Key themes: highly emotional experience, renewed sense of self, Outcomes align with CHIME. Some adverse reactions to the course	NR	Key themes: feeling safe to disclose, two-way process and novel opportunity.	NR
Perkins et al. [72]	NR	Four themes connected to their own wellbeing and recovery. Connectedness to self, self-care. Notable is the mention of reducing stigma of being a professional with MH issues	NR	NR	Sense of competence and morale at work.
Rocca et al. [73]	NR	NR	Significant (small) changes to all measures, which include symptomology of BPD (decreased) and impairment (decreased)	Significant (small) changes to all measures, which include understanding of difficulties common to BPD, (increased)	NR
Stevens et al. [74]	NR	Significant increases in wellbeing. Theme of transforming student lives included positive risk taking, positive social aspects.	Theme of transforming student lives included subthemes of improved mental health. Also, improvement in long-term mental health, although some students stated that improvements did not last	Significant increases in arts participation. Theme of transforming student lives included subthemes of artistic growth, learning skills	NR
Sutton et al. [43]	No difference between those who attended and those who did not on service use variables	NR	NR	NR	Significant association between course attendance and paid or self-employment at follow-up. No difference between those who attended and those who did not on absence from work, unemployment over last 12 months or service use variables

Table 5: Continued.

Author/year	Participation outcomes	Recovery outcomes			
		Wellbeing	Health	RC attendance	Future focus
Thompson et al. [75]	NR	Intrapersonal changes including increased self-awareness, increased confidence and worth empowerment and control	NR	NR	NR
Wilson et al. [46]	NR	No significant difference in wellbeing at 3 months, but there was one at 6 months. Social inclusion significant increase at 6 months. Qualitative data agreed that attendance had a positive effect social inclusion	Qualitative data agreed that attendance had a positive effect on mental health	Qualitative data agreed that the experience was positive and that they would recommend.	NR
Yoeli et al. [44]	NR	Engaging with others online,	Positive changes to mental health	Support from other student, staff and facilitators, felt supported and a part of something bigger	NR
Rinaldi et al. [4]	Students' attendance and service utilisation at 6 months and 12 months postattendance reported.	Students were more hopeful of the future, and live the life they wanted	NR	NR	Students were able to make and achieve goals

Note: NR = Not reported/unclear from the paper.

Table 6: Staff, including educators, and service outcomes.

Author/year	Staff outcomes		Service outcomes	
	Personal	Work-related	Service use/cost saving	Effect on services
Australia				
Cronin et al. [32]	NR	NR	NR	Impact on service use, estimates of cost savings
Hall et al. [47]	Staff reported that working in the college was a positive experience	NR	NR	NR
Hopkins et al. [38]	Changes to perceptions of the college model, use of co-production, cofacilitation and co-reception of courses. The importance of having lived experience staff, and the willingness of clinical staff to be involved. Changes to clinical staff perceptions	Getting clinical staff involved because of rosters/timing of courses could be a problem. Need for managerial support	NR	NR
Muir-Cochrane et al. [34]	Information on staff learning from students.	Care coordinators becoming more recovery-oriented	Care coordinators saw potential for reduction in use of other mental health services	NR
Sommer et al. [35]	Staff talked about the importance of lived experience in colleges, giving inspiration and creating a safe space	Also mentioned changing their perceptions of recovery which led to changes in their practice	NR	Potential impact on service transformation by challenging power dynamics
Brophy et al. [31]	Negative impacts of high workloads on staff wellbeing Empowerment for students who become educators	Professional opportunities for students who become educators	NR	NR
Gill [37]	NR	All clinicians interviewed spoke positively about the benefits of co-production. The clinicians identified that they were able to learn and better understand the consumers' perspectives	NR	NR
Hall et al. [39]	Staff outcomes included opportunities for personal growth, aid in their own recovery and satisfaction of helping others	Staff outcomes included the witnessing personal growth of students, learning from colleagues	NR	NR
United Kingdom of Great Britain and Northern Ireland				
Ali et al. [54]	NR	NR	NR	Need to define College model, clarify any terminology, concepts and definitions to have an effect on auspicing organisation
Bourne et al. [55]	NR	NR	Impact on service use, differences between completing and noncompleting students	NR

Table 6: Continued.

Author/year	Staff outcomes		Service outcomes	
	Personal	Work-related	Service use/cost saving	Effect on services
Crowther et al. [20]	Beneficial impact of staff wellbeing	Changes included softening of established roles, changes in professional practice affected by co-production	NR	Service impact by increase in co-production, more peer workers with less discrimination, willingness to make workplace adjustments
Dalgarno & Oates [59]	Participants mentioned shift in power dynamic could lead to disclosure of own mental health, showing vulnerability	Participants mentioned working collaboratively, more emphasis on what peer brought to the room than the professional expertise, difficulty moving to the peer as a colleague and supporting them in this role, changed how they looked at other training, their use of language and rethink how they saw service user involvement in their practice	NR	NR
Dalgarno & Oates [60]	Sharing more of their own experiences	Co-production was a way of learning the ground rules, looking to lived experience educators for this information, professional staff changing the way they looked at their professionalism	NR	NR
Newman-Taylor et al. [42]	NR	Respondents reported on being stuck in traditional roles and their hope in having alternatives, leading to considerations of change	NR	NR
Perkins et al. [72]	Changes in attitudes, recognising hope and increased parity, empathy,	Changes in meanings of recovery, challenging traditional views, reduction of barriers. Positive impact on supporting others, using or sharing skills, challenging nonrecovery practices	NR	NR
Stevens et al. [74]	Personal confidence increases and positive risk-taking. They appreciated the support and supervision	Participants mentioned development as trainers and overcoming hurdles, developing their practice and professional pride.	NR	NR
Wolverson et al. [77]	NR	NR	NR	Services need to communicate and define clear roles and responsibilities
Zabel et al. [78]	The authors drew the conclusion that staff attendances at RC changed attitudes and behaviours	The authors drew the conclusion that staff attendances at RC changed their practice	NR	The authors drew the conclusion that the potential of RC to change organisations

Note: NR = Not reported/unclear from the paper.

support and adequate resources to minimise the effects of high workloads on staff wellbeing [31, 38].

3.6. Service Outcomes. Only eight documents reported on service outcomes, three from Australia. The outcomes reported included reduction of community service usage for people who attend Recovery Colleges [34, 55], changes around attitudes and ways of working in other organisations interacting with Recovery Colleges [78] and impact on service transformation by challenging power dynamics [35]. They specifically mentioned organisations using co-production and the impact of and on their peer workforce [20], changes in attitudes to recovery and cost savings due to interaction with Recovery Colleges [32] and the need to clearly define the College model and clarify terminology, roles and responsibilities [54, 77].

3.7. Quality Appraisal of the Evidence. The quality appraisal scores of the documents ranged from 0% to 100%, 47 documents were assessed against qualitative criteria, and 35 were assessed against the quantitative criteria, with the mixed methods studies being assessed against them both. Fifteen qualitative and 14 quantitative assessments scored less than the Kmet et al. [30] liberal cut-off score. Most of these documents were mixed-methods research. The majority (80%) of the grey literature sources also scored below the cut-off. Qualitative assessments show that most documents did not include sufficient information on sampling strategies, data collection methods, data analysis methods, the use of verification procedures or reflexivity of the account. Reasons for low scores on quantitative assessment were inadequate question/objective description, no estimates of variance reported, analytical methods not reported/described adequately, results not reported sufficiently or conclusion not or only partially supported by results. As this was a scoping review rather than a more stringent systematic review and was performed to review the extent, range and nature of the publicly available information on Australian Recovery Colleges, all documents were included with the knowledge that the difficulty of assessing the quality of some of the studies is a limitation of this review. The poor quality of the reporting of some of the studies also suggests the need for increased rigour in the reporting of research in the future. The results of the assessment are reported in Table 3 above and in Tables S1 and S2 in the supporting information.

4. Discussion

This scoping review identified 54 studies on Recovery Colleges, 38 from the UK and 16 from Australia; the majority (44) were peer-reviewed articles; and the other 10 documents were grey literature including annual reports, awards applications and evaluation reports. It is unclear from the available information whether Australian Recovery Colleges adhere to the core characteristics outlined by Perkin et al. [1] as the majority of the documents that included information on Recovery College characteristics did not report on all the characteristics. The documents in this review show that there are similarities in the reporting of the core characteristics, student, staff and services outcomes between UK and Australian Recovery Colleges, leading to the belief that Australian Colleges have developed and are implemented in a similar way.

The evidence found in this review corroborates the view that co-production is a critical component in the implementation of Recovery Colleges. Of the core characteristics of co-production, recovery principles, education principles, strengths-based and person-centred focus, availability to all, and location and distinctiveness of the service, co-production was the most cited in the documents in this review. Perkins and Repper [80] maintained that co-production is an integral part of a Recovery College and needs to be used at every stage of development and all of the operations. However, much of the information on co-production in the documents is about developing and facilitating courses, and the use of co-production in other areas of College development and implementation is not highlighted or emphasised, leaving knowledge gaps in what role co-production has in the governance and everyday operation of the Colleges. Some of the documents [5, 31, 37, 75] emphasise co-production as core to their processes and that lived experience is valued, and considered unique [78]; however, there was little to no extractable information on the processes and procedures that are used to incorporate co-production as the basis of the Recovery College model.

The review also supports the importance of Recovery Colleges being recovery-oriented and the value of being an educational service providing co-learning. These two important aspects of the Recovery College model were highlighted by Perkins et al. [81] and others [82, 83] as being central to the core concept of a Recovery College, changing services from individualised symptom-based health services to an educational institution that assists people to live the life that they want to live. Recovery Colleges could become a vital element in the Australian mental health sector by providing education to assist in improving social and economic participation for people with mental health issues [84]. The authors of three of the studies in this review considered Recovery Colleges to be a transformational change in the way 'service' is provided [34, 35, 49], whilst also acknowledging the challenges of implementing this change. The importance of 360° learning is stressed by Perkin and Repper [80] as essential to challenging the attitudes of all involved in a Recovery College, eroding the traditional power relationships and imparting real-life examples of the challenges and realities that people face in their recovery journeys.

As with the case of co-production, the review found little to no extractable information both in Australia and the UK studies on how the core characteristics are specifically implemented in the Colleges. Whilst it is expected that each College develops to suit the needs of their community [1, 3], information on how others have implemented the core characteristics in their Colleges would be useful background knowledge for people involved in developing and implementing Colleges.

Regardless of the lack of information on the implementation of the Recovery College core characteristics, the information on outcomes for students, staff and services involved with Recovery Colleges was similar across the studies in both locations. This suggests that despite the lack of in-depth information on the implementation of core characteristics, Australian Colleges are developing and being implemented in similar lines to UK Recovery Colleges and Colleges across the world [85–87] and having similar outcomes for their participants. There is a lack of information about the students that are attending Recovery Colleges. Hayes et al. [88], who looked at student characteristics across 28 countries in five continents, only reported age and gender for the students. This review found only three articles that report detailed information on the students. This is a gap that needs to be explored in future research. The findings from this review are valuable information for funders, governments and other interested parties as it indicates that existing Colleges in Australia are beneficial for their participants and could possibly be models for the development of more Colleges in the future. However, it is important that these parties are made aware that the one notable difference found in staff outcomes between the two countries is that the Australian documents highlighted the importance of managerial support and adequate resourcing needed to develop and implement Recovery Colleges in Australia. This highlights that stable, sufficient funding for Recovery Colleges, which can lead to a reduction in the use of other more costly mental health service including inpatient stays for their participants, is essential.

More research that explores the influences of culture, funding and environment on the Recovery College Model is critical to obtaining a wide and varied pool of information to assist organisations and governments in setting up Colleges in Australia or in other countries that are looking at this model. The effects of Recovery College participation on all participants involved and the value of Recovery Colleges as an alternative model of care and support to encourage and improve social participation are other areas that need further research. Research in these areas was supported by Hayes et al. [88] in their cross-sectional survey of Recovery Colleges internationally, Killaspy et al. [84] in their research on community-based social interventions and Jones et al.'s [26] review of the operationalisation of RCs and their embodiment of co-production principles. The lack of available studies on the outcomes for communities and society more broadly was disappointing and an area that also needs further research.

This review examined the development and outcomes of Recovery Colleges in Australia and compared this to information available about UK Recovery Colleges. The decision to restrict this comparison was made for several pragmatic reasons, including that the UK was where the first College was developed and the time and resources available to the authors to conduct the review. However, there are Recovery Colleges in over 20 different countries, and it is a limitation of this review that information on these Colleges was not examined, and more research is needed with cross-country comparisons, analysing information from each country separately. The search for grey literature was only conducted once, follow-up searches were restricted to the databases mentioned above, and follow-up searches could have elicited more grey literature to be examined. The quality of some of the studies included in this review was also hard to assess with some documents lacking vital information on how the research was undertaken. Another limitation is the lack of information available on Australian Colleges; there are currently less than 10 Recovery Colleges in Australia that are still open with a further three or four which were trialled or operated but are now closed. Most of the available information included in this review involved only three Recovery Colleges, with another two Colleges having one or two documents applicable to them. There is no publicly available information on about half of the Colleges that ever existed in Australia. Future research needs to explore the development and outcomes of all Australian Colleges.

5. Conclusion

This scoping review found that although there was limited information on how Recovery Colleges have been developed and implemented in Australia, there are similarities in the reporting of the core characteristics, student, staff and organisation outcomes between UK and Australian Recovery Colleges. Recovery Colleges are still a relatively new concept and fledgling model of care in Australia with less than 10 Colleges currently open; however, interest in this model is growing [89] and this review, which summarises the current publicly available information on Recovery Colleges in Australia, will add to the existing evidence on the applicability of the Recovery College model to enhance and diversify Australian mental health services. However, the lack of detailed information on how the model is implemented coupled with the scarcity of information on around half of the currently established Australian Recovery Colleges restricts the practical implementation of Australian Recovery College knowledge. Further high-quality research is needed, that includes more of the Australian Colleges, to gather information on how the core characteristics are implemented in Australia and how this new alternate model of care and support can assist people to live a meaningful life.

Nomenclature

ACT	Australian Capital Territory
ANU	Australian National University
FTE	Full-Time Equivalent
GPs	General Practitioners
JBI	Joanna Briggs Institute
NDIS	National Disability Insurance Scheme
NHS	National Health Service
PRISMA-P	Preferred Reporting Items for Systematic Review and Meta-Analysis Protocols
PRISMA-ScR	The Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews
UK	The United Kingdom of Great Britain and Northern Ireland

Data Availability Statement

Extraction data are available upon request from the corresponding author.

Ethics Statement

The authors have nothing to report.

Consent

The authors have nothing to report.

Disclosure

Neither of the funders had any role in developing the protocol or conducting the review. All authors read and approved the final manuscript. The protocol was registered in the Open Science Framework (https://osf.io/h69fm).

Conflicts of Interest

Dianna G. Smith was employed as the Manager of the ACT Recovery College trial, Australian Capital Territory (ACT), Australia, from April 2019 to June 2022. She was also involved in the codesign and was a participant in the evaluation of the ACT Recovery College. She was not involved in the analysis or writing of the report or subsequent article, and both documents are included in this review.

Lisa Brophy has led two evaluations of Recovery Colleges in Australia. The first was the Mind Recovery College in Victoria [39, 47, 90], and the second was the pilot Recovery College in the Australian Capital Territory [31, 33]. Professor Brophy is also a member of the International Advisory Committee of RECOLLECT—a large research project investigating Recovery Colleges in the UK. Articles on these reviews are included in this review; Lisa Brophy did not perform an extraction on any article or document associated with these reviews.

Alyssa R. Morse and Amelia Gulliver facilitated courses at the ACT Recovery College and were involved in the codesign of, and were participants in, the Evaluation of the College. They were not involved in the analysis or writing of the report or subsequent article, and both documents are included in this review.

Michelle Banfield facilitated courses in the ACT Recovery College and was a participant in the Evaluation of the College. They were not involved in the analysis or writing of the report or subsequent article, and both documents are included in this review.

Terri Warner designed and facilitated ACT Recovery College courses and was a participant in the Evaluation of the ACT Recovery College. They were not involved in the analysis or writing of the report or subsequent article, and both documents are included in this review.

Amelia Yazidjoglou declares no conflicts of interest.

Author Contributions

Dianna G. Smith conceived research, designed research questions, developed and refined the search strategy, performed screening and extraction of all articles and prepared and drafted the protocol and manuscript. Alyssa R. Morse and Amelia Gulliver provided input in the planning of the study, performed a screening and extraction of articles and also reviewed and provided comments, and approved the protocol and manuscript. Terri Warner performed screening of articles. Amelia Yazidjoglou performed screening and extraction of articles. Michelle Banfield provided input in the planning of the study and reviewed and provided comments, and approved the protocol and manuscript. Lisa Brophy performed the extraction of articles and reviewed and provided comments, and approved the manuscript.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.

Supporting Information 1. Supporting file 1: Supporting table S1: Quantitative assessment of documents. Supporting table S2: Qualitative assessment of documents.

Supporting Information 2. Supporting file 2: Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist Recovery College Scoping Review.

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