Recovery Colleges After a Decade of Research: A Literature Review

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Objective: Since the first recovery college (RC) opened in England in 2009, many more have begun operating around the world. The body of knowledge regarding the effects of RCs is growing, suggesting their benefit to recovery, well-being, goal achievement, knowledge, self-management, social support, reduced stigma, and service use. The objective of this review was to establish the state of knowledge about RCs from current empirical literature and to document the methods used to evaluate them.

Methods: In consultation with an international expert panel, two independent evaluators performed a literature review with no date limits on publications in the Medline and Scopus electronic databases.

Results: A total of 460 articles were found, and 31 publications were retained. RC attendance was associated with high satisfaction among students, attainment of recovery goals, changes in service providers' practice, and reductions in service use and cost.

Conclusions: To our knowledge, this is the first literature review of peer-reviewed publications about original studies evaluating the impacts of RCs, including studies pertaining to students, health service providers' practices, education and management practitioners, and citizens. Quantitative studies with a high level of evidence were underrepresented and should be considered as a future evaluation design. Furthermore, outcomes such as empowerment and reduced stigma should be assessed with standardized tools. The impact of RCs on attendees, family, friends, and caregivers and on the everyday practice of health service providers who attend RCs for continuing education or as tutors should also be assessed.

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In many countries, mental health systems face the challenge of providing care and services that are efficient and responsive to the needs of their population (1–3). This challenge requires not only reviewing the allocation of resources but also thinking differently about mental health services and practices and evaluating innovative service models (4–6). The recovery college (RC) model, which is well established in England and Australia, is one new service model that embodies this shift (7–9).

This model proposes an educational approach in the community, where all people (individuals with or without mental health challenges, their relatives, health service providers, education and management practitioners, citizens, etc.) have access to evidence-based training on mental health, recovery, and well-being (8, 9). RCs and their courses are codesigned, coproduced, and cofacilitated by health professionals (experts by training) and people with experiential knowledge of mental health challenges and recovery (peer tutors who are experts by experience) (8, 9). The courses enable students to increase their knowledge and skills on mental health and recovery and their recognition of experiential knowledge and foster recovery-oriented attitudes and behaviors, such as increased self-management and social inclusion and reduced stigma (7, 10).

HIGHLIGHTS

- Attendance at recovery colleges (RCs) is associated with attainment of recovery goals, improved quality of life and well-being, increased knowledge and self-management skills, reduced service use, and changes in service providers' practice.
- This study is the first to include only peer-reviewed publications on original studies designed to evaluate the impact of RCs on service users and providers, and the mental health care system.
- The body of knowledge regarding RCs is growing, but detailed and high-quality investigations on the effects of RCs are now needed.

The first RC opened in England in 2009, and more than 80 RCs are now operating in 22 countries (10–12). Many RCs report having implemented ongoing evaluation practices on the basis of student feedback, standardized questionnaires, and qualitative approaches (11). Since the first RC opened, a body of knowledge about the effects of the model has grown and suggests that benefits arise from attending RCs (9). Evaluation results suggest that the model has a positive impact on recovery, goal achievement, and development of knowledge about mental health and self-management; improves well-being, social support, and employment; and reduces service use (8, 9).

These evaluations have used a variety of designs and have helped improve understanding of the scope of impact RCs can have on individuals, clinical practices, and mental health care systems. This body of knowledge has revealed gaps in the literature and a need for more robust evaluation practices and research. Despite sharing a common culture and values, individual RCs vary in terms of their operation, structure, funding, and fidelity to the original model (10–12), all of which can affect generalizability and comparability. This variation explains why exploring the state of knowledge on the impacts of the RC model is now necessary. The objective of this review was to establish the state of knowledge about RCs from current empirical literature and to document their impact and the methods used to evaluate them in order to identify gaps in the literature and highlight recommendations for future study.

METHODS

According to Grant and Booth's (13) typology of reviews, a literature review involves identifying and selecting the materials for inclusion and synthesizing them (generally in a narrative form) to analyze their contribution or value. The literature review method seeks to identify previous accomplishments, to consolidate information, or to build on previous work in order to avoid duplication and identify omissions or gaps (13). In our case, the rapid expansion of RCs around the world justified a literature review.

We conducted a search on the Medline and Scopus databases. Medline is a leading bibliographic source for biomedical scholarly literature, and Scopus is a database of peer-reviewed literature covering research topics ranging from medicine and social sciences to arts and humanities. A university research librarian was consulted to refine the key words and search strategy. Inclusion and exclusion criteria were determined (J.T. and C.B.) and were tested on 10% of the initial pool of articles, which led to minor modifications. We included original, peer-reviewed studies evaluating the effects of RCs or recovery education centers. We excluded publications pertaining to adult education centers or schools, professional education centers or schools, day hospitals or day programs, traditional psychoeducation treatment, RC annual reports, or single-course evaluations as well as publications in a language other than French or English. (The key words used are available in an online supplement.)

The search was conducted on November 21, 2018. No limits were put on the date of publication. Duplicates were removed, articles were screened by title and abstract, and the remaining articles were read to assess their eligibility. Two independent evaluators performed the screening, sought consensus in cases of discrepancy, and achieved a high level of agreement (>90%). Additionally, the reference lists of retrieved literature reviews were manually screened for potential additional articles. Finally, an international expert panel of three researchers (two from England and one from Australia) with extensive knowledge and experience with the RC model was formed. The experts were presented with all included articles and were asked to recommend additional publications that fit the inclusion criteria and that may have been missed by the team.

RESULTS

Of the 460 articles initially found, 35 were read in full to assess their eligibility. We excluded 14 articles: 11 did not include evaluation data, two did not focus on an RC intervention (articles on a veterans program and a psychoeducation group), and one was a gray literature document (book chapter). The reference list of five literature reviews were manually screened for additional articles. One literature review (7) was excluded because it did not report original results, whereas the four others reported results of qualitative inquiry in addition to the literature review. Consultation with the expert panel led to the inclusion of six additional publications. (A flowchart of the steps taken in the screening process is available in the online supplement.)

Included Publications

A total of 31 publications pertaining to the evaluation of RCs were included in this literature review. Most studies were conducted in England (N=24) and Australia (N=5), with one in Italy and another in Canada. A majority of articles (N=13) presented qualitative evaluation results, and eight articles presented the results of mixed-methods studies. Ten articles presented the results of a quantitative evaluation: three articles on a pre-post design, three survey studies, two presenting descriptive statistics, one correlational analysis on goal attainment, and one service evaluation presenting three case studies.

During the review process, we were aware that other literature reviews (N=5) on RCs had been previously conducted, namely by Meddings et al. (7), Windsor et al. (14), and the RECOLLECT study team (15, 16). These literature reviews included all types of publications (peer-reviewed and gray literature) pertaining to the RC model or other educational models, regardless of objectives or methods. The literature review conducted by Meddings et al. (7) specifically targeted the effectiveness and cost-effectiveness of RCs. The authors used a selective approach and included peer-reviewed publications and gray literature. Among the publications they included, only one was already included in our results. The rest

of their reference list was excluded for not being peer reviewed or not reporting empirical evaluation data. The Windsor et al. (14) literature review focused on recovery education programs, including but not limited to RCs. Of the 25 publications they retrieved, only one was already in our results, and the rest were excluded for the same reasons mentioned above. Of the 44 publications retrieved by the RECOLLECT team (15, 16), 10 were included in our literature review, including three among their 10 key publications. The other publications were not included in our review because they were not indexed as peer reviewed in the databases we selected or they did not report empirical evaluation data.

Table 1 (4, 11, 12, 14–41) presents the articles we included, organized alphabetically and according to their study design. Statistically significant results were not reported systematically across the studies. When available, this information is described in the table.

The RC Model's International Presence

Three studies described the RCs operating in the United Kingdom and internationally. Moreover, they provided a deeper understanding of how RCs operate and who attends them. Two studies provided information about the principles supporting the operation of RCs. Among the 39 RCs surveyed in the United Kingdom in 2017, a majority agreed or strongly agreed that coproduction occurs at every stage of their college (93%), that their college operates on educational principles (97%), that the college is inclusive and open for all (98%), and that the college reflects recovery in all aspects of its culture and operations (11). RCs surveyed outside of the United Kingdom have reported the presence of similar principles of operation, such as recovery, coproduction, education and learning, inclusivity, sustainability, and culture change (12). A majority of UK RCs (92%) reported collecting outcome data from a combination of course evaluation and standardized questionnaires (11). One study aimed to better understand whether an RC's student population was representative of its community in England and in what ways (17). Results showed that students were representative of their community in terms of membership in protected groups often underserved by mental health services—such as lesbian, gay, bisexual, and transgender (LGBT) and black, Asian, and minority ethnic (BAME) populations—but fewer students were elders (60 years old and over) (21).

Positive Impacts of RCs

The positive impacts generated by the RCs studied are presented below and organized under the following topics: students' satisfaction and appreciation of the RCs, goal attainment (namely, social network, knowledge and skills, well-being and quality of life, and education and work), changes in service use, and changes in service providers' practice. Perceived barriers and facilitators to attending RCs are also presented.

Students' satisfaction and appreciation. Many of the studies (25, 26, 28, 29) report a high level of satisfaction among students and tutors and found that students would recommend the RC to others. Some studies also show an attendance rate of 60%−70% (29). Effective collaboration between students and tutors and the value placed on lived experience were themes that students appreciated about the RC (32, 36). Self-stigma (internalization of negative views of others such that a person comes to hold those beliefs about him or herself) was assessed in a pre-post study, which found a statistically significant reduction in self-stigma among students after attending an RC (22).

Goal attainment. Studies showed that students made progress toward attaining personal goals. Those goals are reported below in the subjects of social network, knowledge and skills, well-being and quality of life, and education and work.

Some recovery goals identified by students were oriented toward socialization, and attending the RC helped them improve their social network (21). In many studies, students talked about how the RC strengthened their social network and offered opportunities for meaningful interactions (28–30). One study reported that students showed a significant increase in the numbers of friends with whom they could talk about their mental health after attending an RC (4). For some participants attending RCs, contact with others motivated change and facilitated understanding of new perspectives (40). These students explained that they reflected on their experiences and were more hopeful (40).

Increasing knowledge and skills was also an important goal for people attending RCs (23) and emerged as a common theme in many of the studies (24, 26, 27, 29). Participants reported that they had access to knowledge and learned new information. Other participants expressed that they improved their understanding of recovery and increased their knowledge of themselves (24, 27). In Zabel et al. (41), participants explained that attending the RC helped them gain self-management skills that they felt able to transfer to everyday situations.

In terms of positive impact, progression toward the recovery goal of increased well-being and quality of life was reported as a result of attending an RC (23). Five studies (4, 20, 22, 25, 31) reported statistically significant improvement in well-being, quality of life, and recovery after attending an RC. In an Italian RC study (26), students expressed that attending the RC helped them adopt and maintain a healthy lifestyle. Some participants also showed statistically significant improvement in measures of empowerment after attending the RC (25, 31). In another study (38), attending the RC was associated with a widening horizon (i.e., opening to new perspectives) and an increase in confidence. Other studies (16, 35, 37) reported that the RC had a personal impact on the students attending, specifically on self-esteem and self-confidence. Some results have gone further, and participants expressed that attending the RC helped them gain a renewed sense of self. One study (23) concluded that students attending RCs had a 73% likelihood of partially or fully achieving their goals and a 39% likelihood of achieving

TABLE 1. Characteristics of the studies (N=31) included in the review of the impact of recovery colleges (RCs), by study design[a]

Study	Country	Sample	Goal and methods	Main results
			Quantitative studies	
Anfossi, 2017 (11)[b]	England	N=39	Goal: To explore the current state of RCs in the UK. Methods: Survey.	Outcomes evaluation: The majority of RCs collect outcome data (92%). Support and collaboration: The majority of participants stated that their college follows the defining features investigated (coproduction, educational, inclusive, reflects recovery).
Bourne et al., 2018 (17)	England	N=463	Goal: To evaluate service use outcomes for Sussex RC students who use mental health services. Methods: Controlled-before-and-after design with archival data.	Completed group (attended>70% of RC course): Significant reduction in occupied bed days, admission, community contacts over 18 months; significantly greater reduction in the number of admissions than noncompleted group (attended<70% of RC course) over 18 months. Noncashable cost savings estimated to be £1,200 per year per registered student who uses secondary mental health services (net savings of 22%).
Chung et al., 2016 (18)	Canada	N/A	Goal: To describe a recovery education center, the Supporting Transitions and Recovery Learning Centre. Methods: Descriptive statistics.	After attending one course, 60% of students attend the subsequent months, while 39.7% of students engaged in continuing education in the community. Students' positive feedback: More solid social network, a more valued life, and social, educational, and vocational skills.
Dunn et al., 2016 (19)	England	N=16	Goal: To explore the barriers to attendance of RCs and possible improvements. Methods: Survey.	Personal factors: Physical illness (69%), other commitments or life events (50%), worrying about other students (44%), being anxious (38%), not knowing what to expect (25%). Practical factors: Distance (60%), cost of travel (38%), inconvenient time of day for class (25%), communications issues (25%), etc. Students found individual learning plans to be helpful and to improve attendance.
Kay and Edgley, 2019 (20)	England	N=3	Goal: To evaluate cost efficiencies and health outcomes after 1 year of course delivery in an RC. Methods: Service evaluation and case study data evaluation (N=3).	Significant impact on health outcomes (WEMWBS, PAM); improved employment opportunities for students (not specified if significant); 57% (N=176) of students were service users of secondary care; two-thirds showed reduction of contacts with care services, suggesting potential cost savings between £1,000 and £2,000 per person per year ($1,200 to $2,500 USD).
King and Meddings, 2019 (12)[b]	England	N=25	Goal: To provide a preliminary outline of the international presence, commonality, and differences between RCs. Methods: E-mail survey.	RCs in 22 countries in five continents; participants rated stigma in their country as high and rated use of recovery approaches as low; top common reasons for developing an RC were to transform the organization and change attitudes and culture (N=10), to serve the needs of the community (N=8), and to act on inspiration from visiting other RCs (N=3). Common themes identified were recovery, coproduction, education and learning, inclusivity, sustainability, and culture change.
Meddings et al., 2015 (4)	England	N=35	Goal: To evaluate two pilot RCs. Methods: Pre-post design.	High level of student satisfaction: 97% reported that they would recommend the course they had completed. Significant progress on recovery goals: Most commonly gained confidence, increased knowledge and/or skills, and met other people. Large (statistically significant) gains on PQR, CHOICE, WEMWBS, MANSA. Significant increase in number of friends with whom students can talk about mental health.
Meddings et al., 2019 (21)	England	N=2,296	Goal: To explore whether one RC reflects its community. Methods: Audit analysis and descriptive statistics.	RC students were representative of the local community in terms of membership in protected groups often underserved by mental health services, such as LGBT and BAME, but fewer students were elderly (≥60 years) or men.

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TABLE 1, *continued*

Study	Country	Sample	Goal and methods	Main results
Nurser et al., 2017 (22)	England	N=58	Goal: To measure whether RC courses address self-stigma. Methods: Repeated (within-subjects measure) pre-post design.	QPR (statistically significant) increased following course attendance (mean±SD=35.78±10.97 before attendance vs. 43.09±8.48 after), indicating that students felt more progress toward recovery after attending. ISMI-10 decreased from 2.34±0.53 to 2.12±0.56, indicating students felt less self-stigma following attendance.
Sommer et al., 2019 (23)[b]	Australia	N=64	Goal: To examine the type of goals that RC participants set. Methods: Correlational quantitative analyses.	Most common goals: Education, socialization, general medical health, mental health, and employment; 73% of goals were fully or partially achieved. Students with higher attendance and who attended more courses were more likely to achieve their goals at least partially. Employment goals were significantly less likely to be achieved than other goals (perceived as more difficult to achieve than other goals). Education-related goals had the highest probability of being achieved, followed by mental health, social, and general medical health goals.
Mixed-methods studies				
Burhouse et al., 2015 (24)	England	N=50	Goal: To test if RCs offer hope, knowledge, and practical skills in self-management and support recovery. Methods: Mixed design with pre-post course evaluation questionnaires and focus group.	Quantitative results (statistical significance not reported): 94% of students reported feeling more hope after attending classes; 91% of students reported having increased their knowledge and better knowledge of themselves; many improved their self-management skills (self-confidence, self-control, daily routines, and understanding of others); 100% of students progressed toward their recovery goals. Qualitative results: Individual transformations (sense of belonging, ability to contemplate the future, feeling safe at the RC).
Ebrahim et al., 2018 (25)	England	N=56–89	Goal: To evaluate the impact of engagement with an RC on student well-being. Methods: Mixed design with pre-post feedback questionnaires.	WEMWBS: statistically significant difference/improvement between pre-post terms. Empower Flower: statistically significant difference/improvement between pre-post terms. Student feedback: 90% of students had more confidence in their abilities afterward as well as increased motivation; 84% of students felt more confident around people; 94% reported they would be "extremely likely" or "likely" to recommend the RC to friends and family. Themes in students' comments: quality of recovery-supporting care (unique contribution, fight stigma, and safe place), achievement of individual recovery goals (learning, social support, and social skill); subjective measures of personal recovery (feeling more hopeful about the future), achievement of socially valued goals (work/volunteering and recovery), quality of life and well-being (sense of purpose and confidence, encouragement to leave the house and to feel a part of something), measurement of service use (reduction in use of services, fewer visits to general practitioner, less use of mental health services).
Hall et al., 2018 (26)	Australia	N=51	Goal: To study the implementation process and measure intermediate outcomes for people who engaged with an Australian RC. Methods: Coproduced mixed-methods design (implementation study).	Satisfaction highest for "staff respect of students" and "safety and comfort of the service." Environment oriented toward promoting learning and growth and being inspiring and encouraging; staff were caring and compassionate. Interviews: Students reported a positive impact on education and learning, providing them with access to knowledge; encouraging them to adopt and maintain a healthy lifestyle; employment. Attending the RC gave students the opportunity to participate as peer facilitators.

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TABLE 1, *continued*

Study	Country	Sample	Goal and methods	Main results
Hopkins et al., 2018 (27)	Australia	N=46	Goal: To understand why young people and adults enrolled in a coproduced, co-received RC. Methods: Mixed design, quantitative and qualitative pre-post survey.	Young people: 50% (N=19) participated in the course to improve their knowledge of the course content; 32% (N=12) hoped to increase their personal self-knowledge and understanding; 10% (N=4) hoped to gain new perspectives on the course subject matter. Adults: A majority (47%) enrolled to improve their knowledge of the course content; 17% (N=5) hoped to increase personal self-knowledge; 13% (N=4) hoped to gain new perspectives; 10% (N=3) enrolled in a course with the hope of improving their understanding of how the RC works. Factors that could help them get the most out of the course: Among young people, speaking up (18%, N=7); flexible learning environment (8%, N=3); safe, respectful, and supportive environment (21%, N=8); engaging course content (16%, N=6). Among adults, speaking up (30%, N=9); safe, respectful, and supportive environment (20%, N=6), engaging course content (7%, N=2).
Lucchi et al., 2018 (28)	Italy	N=42 staff; N=34 service users	Goal: To describe the process of planning, implementing, and evaluating the first RC in Italy Methods: Mixed-methods design (implementation study).	Staff (tutors) considered the educational process to be of very good quality; project completely met their expectations (50%). Their involvement changed the way they worked with service users. Service users reported an enjoyable and valuable experience; 65% rated their learning process as very good; 35% rated it good; 70% found it useful for improving their quality of life and personal aspirations. Focus group reported that **s**tudents acquired new competencies through the courses and were able to make new social connections; approach to coproduction was found to be very good and was described as challenging, useful, and satisfying; staff members recognized the RC model as a valuable tool to enable services to support individual recovery journeys.
Meddings et al., 2014 (29)	England	N=40	Goal: To explore students' perspective on what they consider makes the RC effective. Methods: Mixed design, course feedback, and qualitative interviews.	Feedback forms: 96% of students said that the course was good or excellent; 97% of students said they would recommend it to friends, family, or colleagues. Students reported improved self-esteem, more confidence, and a sense of achievement. The following categories describe what made the RC helpful: learning with others, coproduction and value of lived experience, safe supportive environment, learning new knowledge, social opportunity, structure of the day, and choice.
Perkins et al., 2017 (30)	England	N=94	Goal: To explore the impact of attending the RC on health service providers. Methods: Online survey with descriptive statistic and thematic analysis.	Themes were identified for change in attitudes toward mental health and recovery: new meanings of recovery, challenging traditional views on recovery, hope for recovery, increased parity (the RC positively influenced the way students supported others and increased understanding and empathy), challenging nonrecovery practices, and adopting recovery practices. Other themes included impact on personal well-being, connectedness, safe place, self-care, and a sense of competency and high morale at work.
Stevens et al., 2018 (31)	England	N=17–28	Goal: To evaluate arts activities on the well-being of students. Methods: Mixed design, pre-post course questionnaires.	Statistically significant increases in mental well-being and range of arts activities following course attendance. Themes for students included that courses improved service users' mental well-being and promoted artistic growth; students learned skills and engaged in positive risk-taking; the positivity of social aspects of courses was important for many service users. Themes for peer tutors included increased confidence and self-esteem; appreciation for support and supervision. At follow-up, 17 of 24 students reported improved mental well-being, increased social inclusion, and continued use of skills learned in the course to maintain well-being.

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TABLE 1, *continued*

Study	Country	Sample	Goal and methods	Main results
			Quantitative studies	
Cameron et al., 2018 (32)	England	N=13	Goal: To understand how RC students and tutors experience the design and delivery of a mental health course. Methods: Qualitative case study. Analysis: Qualitative thematic.	Important themes: Effective collaboration between tutors is a key aspect. The use of lived experience expertise was not confined to that shared by peer trainers. The valuing of lived experience on par with practitioner and academic experience meant that the practitioners and academics felt it legitimate to draw on relevant aspects of their own lived experience. The environment and methods of learning had a significant impact and should be considered alongside content. Boundaries that arise between people regarding areas of knowledge and experience can be viewed as sources of creativity that can enrich courses.
Crowther et al., 2018 (15)	England	N=33- member advisory panel	Goal: To develop a stratified theory identifying candidate mechanisms of action and outcomes (impact) for RCs at the staff, services, and societal levels. Methods: Unspecified. Analysis: Inductive thematic.	At the staff level, experiencing new relationships may change attitudes and professional practice. Identified outcomes: Experiencing and valuing coproduction; changed perceptions of service users; and increased passion and job motivation. At the services level, RCs sometimes develop separately from their host system, reducing the impact of the college on the organization but allowing the development of an alternative culture. At the societal level, partnering with community-based agencies gave the public opportunities for learning alongside people with mental health problems and enabled community agencies to work with people they might not have otherwise. RCs also provided opportunities to beneficially influence community attitudes, thus reducing negative assumptions about people with mental health challenges.
Dalgarno and Oates, 2018 (33)	England	N=8	Goal: To explore the meaning of coproduction for clinicians in an RC. Methods: Exploratory case study. Analysis: Qualitative thematic.	The "meaning of coproduction" had four themes: definitions, power dynamics, negotiating roles, and influence on practice. Reassessment of the clinician's expert role and power changed their practice, the language they used, and the personal information they shared. The mechanisms by which coproduction may transform professional practice included being in an educational rather than a clinical context, the experience of being supported, the challenge of negotiating multiple roles, and experiencing a gradual shift of role emphasis as cotrainer relationships developed. Being a practitioner trainer could be a professionally transformative experience.
Frayn et al., 2016 (34)	England	N=8	Goal: To describe the development process of an RC approach in a forensic psychiatry environment. Methods: Unspecified. Analysis: Unspecified.	Two themes emerged: The objective of the RC to support a shift in emphasis from treatment to education; staff felt they related to students in a more constructive way. The value of cofacilitation shared by all; students were inspired by meeting people who got back to the community. Experiential knowledge is considered facilitating.
Gill, 2014 (35)[b]	Australia	N=6	Goal: To explore the value of coproduction in the context of the recently established South-Eastern Sydney Recovery College. Methods: Unspecified. Analysis: Unspecified.	Peer educators: Value of coproduction included benefits self-esteem, personal and professional growth, hope and meaning, improved network, skills; codelivery challenging but positive, felt valued and respected. Clinicians: Reported better understanding of service users, new knowledge acquired, challenging move away from traditional power dynamic, support and training required to get the most out the coproduction paradigm. RC team: rapid growth was a challenge; underestimated the support and training required.

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TABLE 1, *continued*

Study	Country	Sample	Goal and methods	Main results
Harper and McKeown, 2018 (36)	England	N=4	Goal: To explore students' motivations for enrollment and attendance with RCs. Methods: Unspecified. Analysis: Thematic.	The following themes emerged: Making the effort: attendance sometimes required great effort because participants had little energy left but were motivated to learn and socialize; they forced themselves to attend for the good it will do and because it is part of their recovery. Being "too unwell": illustrates the struggle of learning in the presence of mental health difficulties; participants reported to continue attending even if they felt too unwell because they believed RC could work. Friendly environment: appreciation of the tutors had positive effects on participants' experience and learning; they found the group dynamic positive; participants expressed that RC temporarily reduced their symptoms.
Martina, 2015 (37)	England		Goal: To collect information and students' comments on the course "Poetry for Recovery." Methods: Unspecified. Analysis: Unspecified.	Students appreciated the dynamic between tutors, found them friendly, encouraging, and supportive. Students reported enjoying hearing each other's stories and found the course was a good bonding opportunity. The course helped them deal better with mental illness. Writing helped them manage moods and feelings during recovery. They said the course gave them a confidence boost.
Newman-Taylor et al., 2016 (38)	England	N=11	Goal: To assess the impact of the RC in the context of pilot study. Methods: Unspecified. Analysis: Thematic.	Overall theme of connecting with others differently emerged as well as three subthemes: reflection on "stuckness," quality of relationships to enable change, and widening horizons. The change of paradigm elicited by coproduction was recognized as enabling students to engage with each other. Students reflected on their experiences and were more hopeful. Contact with others motivated change and facilitated understanding of new perspectives. The broadening of horizons was associated with moving on and growing in confidence after attending the RC.
Nurser et al., 2018 (39)	England	N=8	Goal: To examine individual experiences of a personal storytelling course in an RC. Methods: Phenomenology. Analysis: Interpretative phenomenological.	Five key themes: highly emotional experience, feeling safe to disclose, renewed sense of self, two-way process, and novel opportunity. Individuals gained a renewed sense of identity from connecting with their emotions and experiences through telling their story. Feeling safe facilitated richer disclosure by participants.
Sommer et al., 2018 (40)	Australia	N=29	Goal: To explore the experiences of students who attended the South-Eastern Sydney Recovery College. Methods: Exploratory, descriptive qualitative design. Analysis: Thematic.	Four themes emerged from the thematic analysis: Connection with others: Validation that they received, the sense of connection. Hope for the future: Reinforced by a sense of connection with others; RCs gave skills and confidence to manage recovery and move beyond mental illness; opened pathways to education and employment. The importance of lived experience: Tutors highlighted the importance of involving people with lived experience with mental health concerns in the processes of cofacilitation and co-learning; the inclusion of both of people with lived experience and clinical staff as students sitting side by side was valued. Changing attitudes and systems: Renewed and deepened understanding of the meaning of recovery; staff described how this new insight into recovery was having an impact on their clinical practice; incorporating a recovery philosophy into practice required changes to current systems through shifting the orientation.

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TABLE 1, *continued*

Study	Country	Sample	Goal and methods	Main results
Toney et al., 2018 (16)	England	N=33	Goal: To coproduce a change model characterizing mechanisms of action and outcomes of RCs. Methods: Unspecified. Analysis: Deductive.	Four mechanisms of action for RCs: empowering environment (safety, respect, and supporting choices), enabling different relationships (power, peers, and working together), facilitating personal growth (e.g., coproduced learning, strengths, and celebrating success), and shifting the balance of power through coproduction and reducing power differentials. Outcomes: Change in the student (e.g., increases in self-understanding and self-confidence) and changes in the student's life (for example, occupational, social, and service use).
Windsor et al., 2017 (14)	England	N=10	Goal: To critically appraise the existing evidence of recovery educational programs in mental health. Methods: Unspecified. Analysis: Thematic.	Coproduction and education and recovery programs led to a reduction in the use of health services, increased opportunities for future employment, and a positive impact on staff. The college brought safety, empowerment, and stimulation; other important themes included increased confidence, motivation, and social interaction. Positive qualities of RCs included a safe and supportive environment, social opportunity, a chance to learn from other students, the chance to meet people who had similar experiences, and learning from a mixed group. Focus group: Many different outcomes (benefits) were reported, including improved general well-being, confidence, motivation, and social interactions. It is notable that there was a clear lack of negative comments.
Zabel et al., 2016 (41)	England	N=21	Goal: To explore the subjective experience of people involved in RCs. Methods: Unspecified. Analysis: Thematic.	Four main themes: Ethos of the RC, personal and organizational impact, value of coproduction, and barriers to engagement. Participants appreciated the inclusive nature of the RC and felt supported by tutors. Hope is a theme that was appreciated for its positive impact on students. Participants reported that the RC environment was supportive, nonjudgmental, safe, and even destigmatizing. They developed several self-management skills that they felt they were able to transfer to different situations. The RC helped them get out of the house and to complete their routine. Participants also felt that RCs could improve services, change practice by sharing information among colleagues, and lead to savings by reducing hospitalizations. Coproduction was an RC principle that participants valued and appreciated.

[a] BAME, black, Asian, and minority ethnic; CHOICE, Choice of Outcome in Cognitive-Behavioral Therapy for Psychosis; ISMI-10, Internalized Stigma of Mental Illness; LGBT, lesbian, gay, bisexual, and transgender; MANSA, Manchester Short Assessment of Quality of Life; N/A, data not available; PAM, Patient Activation Measure; QPR, Questionnaire about the Process of Recovery; WEMWBS, Warwick and Edinburgh Mental Well-Being Scale.

[b] Publication recommended by an international expert panel of researchers with extensive knowledge and experience with the RC model.

more than they had expected. Students with higher attendance rates and higher number of courses attended were more likely to achieve their goals and to achieve more than expected.

For some students, recovery goals are oriented toward integration in or return to school or work (23). A correlational study (23) reported that students had a higher probability of achieving education-related goals compared with employment goals, the latter being perceived as more difficult to achieve. The results of Kay and Edgley's study (20) showed that attending an RC resulted in an improved pathway to studying, volunteering, and paid employment for students. Similar findings of increased academic pursuit were presented in a study of a Canadian RC (18).

Change in service use. Several studies reported a positive impact on service use. In the context of a pre-post methodology analyzing archival data of people attending RCs, Bourne et al. (17) reported a significant reduction in service use (occupied beds, admission, community contacts) among students who attended an RC. Results also showed a significant reduction in service use among individuals who completed at least one course compared with those who attended less than 70% of a course or who only registered (17). The authors suggest that this reduction in service use can result in a noncashable cost savings of £1,200 (estimated $1,500 USD) per year per student using secondary mental health services. Kay and Edgley (20), a study based on service evaluation that presented descriptive statistics and three case studies, showed similar findings. The authors reported that two-thirds of RC students using secondary mental

health services showed a reduction in service use after attending the college. They estimated that this reduction could lead to a cost savings of £1,000 to £2,000 (estimated $1,200 to $2,500 USD) per student annually (20).

Change in service providers' practice. Four studies reported the benefits of health service providers (clinical staff) attending RCs as students or serving as tutors. Providers reported having acquired new knowledge after attending the RC (35). The experience of coproduction changed their perceptions of people who use services and increased their passion and motivation at work (30). Experiencing new relationships changed the attitudes and professional practices of clinicians after they attend an RC (15, 30). Similar findings have been reported in other studies. The participants experienced a shift from the power dynamics to which they were accustomed and reported that the experience changed their professional practice, the language they use, and the information they share (33, 35). Staff attending the first Italian RC also reported that their involvement in an RC changed the way they work with service users (28). Two studies (15, 30) also highlighted that RCs had a positive impact on health services, by developing a peer workforce, and on a societal level, by changing attitudes and beliefs within the community about people with mental health challenges.

Barriers and facilitators to attending an RC. Some studies allowed us to understand the perceived barriers and facilitators to RC attendance. One survey study (19) explored the perceived barriers to attendance and suggested recommendations to address those barriers. The most common reasons for students not attending class at the RC were personal, such as physical illness (69%), other commitments or life events (50%), worrying about other students (44%), being anxious (38%), and not knowing what to expect (25%). Other reasons concerned practical factors associated with the RC, such as distance (60%), cost of travel (38%), inconvenient time of day for class (25%), and communication issues (25%) (19). In another study (36), participants identified low energy level and illness due to mental health challenges as the main obstacles to attendance. However, the students reported that they sometimes forced themselves to attend class because attendance was part of their recovery journey and found that the positive group dynamic with the tutors was beneficial for them and made them glad they came (36). Other students found the individual learning plan and clear communications, including text or phone call reminders, helpful in improving attendance (19). Students also reported that experiential knowledge was a facilitating element in the courses and that they valued the shift in favor of education in lieu of treatment (34). In other qualitative studies, students recognized that the paradigm shift toward coproduction enabled them to engage with each other (14, 40, 41).

Methodologies Used to Evaluate RCs

Qualitative designs. Among the 31 articles included, 42% (N=13) used qualitative methods, 32% (N=10) had quantitative designs, and 26% (N=8) were mixed-methods studies. The qualitative studies have enabled a deeper understanding of the perspectives of the various individuals attending RCs and the benefits they perceived, namely, increased self-management, self-confidence, and knowledge. Some studies also illustrate a transformation toward a paradigm that promotes equity between health providers and people with lived experience and that values experiential knowledge (15, 33, 35). Among the qualitative studies (N=13), only four specified the type of methods used, namely, case studies (32, 33), exploratory descriptive qualitative methods (40), and phenomenology (39). Six articles did not report the methods used, but only the type of analysis conducted (generally thematic analysis and inductive or deductive analysis) (14–16, 36, 38, 41), and three other articles did not report the methods used or the type of analysis conducted (34, 35, 37). The standard for methodological rigor most often reported in those studies was co-coding of material or group consultation to agree on analysis.

Quantitative designs. A total of 10 articles presented the results of a quantitative evaluation. Of those, three studies used a pre-post design methodology to evaluate student outcomes and efficiency (4, 22) and service use (17). Using a survey methodology, three other studies reported on the current state of RCs worldwide (11), the differences among RCs internationally (12), and the barriers and facilitators to attendance (42). Other studies presented descriptive statistics on students' feedback (18), cost efficiency, health outcomes (20), and whether the RCs were representative of their local community (21). One other study was a correlational analysis on goal attainment (23). Among all of the quantitative studies, four used standardized assessment tools, namely, the Patient Activation Measure, Warwick-Edinburgh Mental Well-Being Scale, Manchester Short Assessment of Quality of Life, Choice of Outcome in Cognitive-Behavioral Therapy for Psychosis, Process of Recovery Questionnaire, Internalized Stigma of Mental Illness Scale, and Goal Attainment Scale (4, 19, 21–22).

Mixed-methods designs. Among the mixed-methodologies studies (N=8), six articles pertained to course evaluation: four studies used a pre-post questionnaire followed by an interview (individual or group) (24, 25, 29, 31), and two studies used a survey with both quantitative and qualitative questions (27, 30). The two others were implementation studies reporting on the implementation process in early stages of the development of RCs and various outcome measures (satisfaction, perceived benefits of attending in terms of knowledge and competencies, improved pathway to study or work) (26, 28). Hall et al.'s (26) implementation study used two standardized assessment tools: the Mind Australia Satisfaction Survey and the Developing Recovery Enhancing Environment Measure.

DISCUSSION

This review aimed to establish the state of knowledge of empirical literature about RCs and the methods that have

been used to evaluate them. RC attendance is associated with beneficial outcomes among people with mental health challenges, health care providers, and mental health care systems. Studies showed that the RC model is present worldwide and has an impact on multiple outcomes: recovery, well-being and quality of life, social relations, internalized stigma and discrimination, employment and community activities, culture change, cost saving, and service use.

However, some outcomes were less explored. Internalized stigma was assessed with a standardized tool in only one study (22). No other study evaluated the effect of RCs on reducing stigmatic attitudes and behaviors among students, RC staff (tutors and other team members), health care providers and managers who attended RCs, and community members. This omission is surprising considering that RCs are renowned for having an impact on reducing stigma, discrimination, and stigmatizing attitudes and behaviors (8–10). Empowerment is another outcome that has not been thoroughly assessed. Results regarding empowerment were reported only in qualitative studies. This is an important limitation to address because standardized tools are available to measure empowerment and because empowerment is an important personal goal for people attending RCs (16).

Also, the results on cost savings and reduction of service use, although promising, should be carefully considered. The method used, namely, archival data evaluation pre-post RC attendance (17, 20), do not consider the influence of participants' background characteristics on the results. Insufficient information on participants' background characteristics (for example, on life context, life events, or available support) could induce bias.

Quantitative designs aimed at evaluating RCs' effects are well represented (N=10) but are mainly pre-post designs, surveys, and presentations of descriptive statistics. These studies used designs with low levels of evidence, which do not lead to strong conclusions about the effects of the RC model. At the time the data were collected and analyzed, no randomized-controlled trial (RCT) or longitudinal study had been conducted to evaluate the effects of the RC model, despite many recommendations (7, 10).

The results of this literature review show that Meddings et al.'s (7) recommendation that qualitative and mixed-methods studies be conducted to evaluate the impacts of the RC model has been followed. Eight mixed-design studies were found in the review. The qualitative component of the mixed studies allowed a better understanding of the impact RCs have on personal variables such as self-management skills and sense of self, although these variables were not measured with standardized tools. This is an important finding because RCs are environments rich in diversity and because the positive experience of RC attendance could be an important indicator of the colleges' sustainability. This review generated an important body of knowledge highlighting the model's mechanisms of change, which many studies stressed (7, 10).

The results of the qualitative studies reviewed highlight how significant the RC model can be at the individual and system levels. This is valuable information for organizations operating RCs and collaborating with them (10). Although many of the qualitative studies were co-developed, because co-development is a core principle of the RC model, very few report on criteria for qualitative methodological rigor, namely, credibility, transferability, and dependability. This omission constitutes the principal limitation to the findings of these studies.

Future Directions

The results of this first empirical literature review of studies evaluating the impact of RCs pave the way for promising perspectives in the future. First, the impact of attending an RC should be assessed in an inclusive manner across all student groups, regardless of whether they use mental health services. This practice would align evaluation efforts with the principles of diversity and inclusion at the core of the RC model. Most studies have obtained data for students who use services. Studies in which all students have been included have not consistently reported how many of those students use services nor explored similarities and differences in outcomes between the two groups. Less information is available for friends and family members of RC students and for other community members. Informal feedback of family members and friends of students attending an RC has been positive, but more formal evaluations need to be conducted (10). Additionally, evaluating how RCs influence stigmatic attitudes and empowerment for all students should be part of ongoing research efforts (22), and these outcomes should be thoroughly assessed by using standardized tools. Studies should also assess how representative RC students are of the general population in order to implement initiatives that target populations sometimes underrepresented in RCs or mental health services, namely, older people, younger people, men, and members of BAME and LGBT groups (21, 43).

Second, evaluating the impact of continuing education at RCs among health service providers should also be part of assessing the effects of RCs (10), specifically the effects on providers' mental well-being, attitudes, and perceived sense of competency. Future research should also evaluate the impact of attending RCs at the practice level. For example, what knowledge and skills do providers acquire, and how do they use them in their practice? How does the balance of power shift in their relationship with service users, and how does this shift affect everyday practice (15, 33)? Additionally, assessing changes in stigmatic attitudes and behaviors of students, tutors, health and management practitioners, and citizens should be a part of the ongoing outcome evaluation of RCs in order to document their effects at the system level.

Third, as the results showed, RCs are located around the world, and despite the common culture and values they share, various models of operation can be identified (10–12, 43).

Although the RC model has key principles that define it—coproduction, co-learning, a focus on recovery, an empowering environment, enabling different relationships, shifting the balance of power, and promoting personal growth (16)—future research should consider documenting the degree to which the model can be adapted while retaining fidelity to those principles (9). In doing so, this research may allow RCs to demonstrate that they provide an enabling environment, rich in diversity, that meets the goals of social inclusion and fights stigma and discrimination (10). Future research could also benefit from initiatives documenting the mechanisms involved in co-learning and exploring how co-learning can be fostered (30).

Fourth, research efforts should extend beyond traditional mental health populations initially targeted by RCs (people with serious mental health challenges, such as psychosis, bipolar disorder, anxiety disorder, or depression) because courses covering many topics are now offered. Other groups, such as youths and seniors, should also be considered in the development of RC programs. Many youths experiencing mental health challenges look forward to improving their knowledge and skills in order to manage their health, increase their personal self-knowledge, and gain new perspectives and hope (27). They seek to receive services that are supportive and respectful in an environment that promotes learning, such as RCs (43). Learning opportunities for seniors are already present in the community, but a majority place seniors in an essentially passive role. In this context, the adaptation of the RC model for an aging population seems to meet a pressing need for this population. Research should evaluate how the RC model can be adapted to these populations and respond to their mental health needs for knowledge and empowerment.

Fifth, future research initiatives should be developed around sound methodologies. In pioneering articles on RCs, recommendations for future research were to conduct long-term follow-up studies. This suggestion was not reflected in the studies we reviewed; no long-term studies were available at the time of this review. Many articles we reviewed still stressed the importance of conducting long-term studies to evaluate the effects of RCs. Longitudinal studies could measure the longer-term impacts of RCs and the sustainability of results and document the students' progression toward employment and mainstream education (7, 20, 23, 27, 31, 40). Although following participants may be challenging over the long term, doing so could also support the findings about the financial impact RCs have on mental health service use (7, 17, 20, 25). Many authors recommended that research with a higher level of evidence, such as RCTs, be conducted to better investigate the causal link between RCs and positive outcomes (7, 17). Of course, research efforts should be oriented toward obtaining strong evidence about the effects of a complex intervention like RCs. However, researchers must reflect on how this level of evidence can be achieved without compromising the core principles of the RC model.

Limitations and Strengths

Despite the methodological steps followed to undertake this literature review, some limitations remained. The analysis of the data collected may have been limited due to the diversity of data reported (quantitative, qualitative, and mixed). Also, although two evaluators carried out the screening and an expert panel was consulted for the inclusion of additional articles, some articles may have been missed.

However, one of the unique contributions of this review is that, to our knowledge, it is the first to include only peer-reviewed publications on original studies with designs aimed at evaluating the impacts of the RC model at every level (students/service users, relatives, citizens, clinicians, RC staff, communities, service organizations, and service providers). It reinforces the importance of conducting studies with a high level of evidence on the effects of the RC model.

CONCLUSIONS

This review shows that the body of knowledge regarding RCs is growing. Benefits of attending RCs include a high level of satisfaction among students; attainment of recovery goals; improved quality of life and well-being; increased knowledge and self-management skills; reduction of service use; changes in service providers' practices, including a more egalitarian relationship with service users; and transformation of attitudes and beliefs. However, the results of this study highlight the need for detailed and high-quality investigations on the effects of RCs. Obtaining more conclusive evidence should be a priority for future research initiatives on RCs in order to give organizations the confidence necessary to invest in the RC model (20, 38, 40).

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