A comprehensive review of the existing structures and processes in the delivery of recovery education within the HSE Mental Health Services.

HSE

HSE Mental Health Engagement & Recovery

Catherine Brogan Consultancy

A comprehensive review of the existing structures and processes in the delivery of recovery education within the HSE Mental Health Services.

Contents

Acknowledgements

On behalf of the authors of this review, Catherine Brogan and David Dwyer, we would like to extend our heartfelt thanks to everyone who supported the process which has resulted in this report on Recovery Education in Mental Health Services;

- The Participants in Recovery Education across the Recovery Colleges and Recovery Education Services
- The Recovery Co-ordinators, Peer Educators and Recovery Education Facilitators
- The Team in the National Office for Mental Health Engagement and Recovery
- The Management and Staff of the HSE
- The Management and Team of Mental Health Ireland
- Wise Eyes Creative

We hope that the report will support the co-production of the National Strategy for Recovery Education in Mental Health Services and these valuable services will grow and strengthen.

Foreword

Michael Ryan
Head of Mental Health Engagement and Recovery, HSE, Ireland

It gives me great pleasure to contribute the foreword for this report on the comprehensive review of the existing structures and processes in the delivery of recovery education within the HSE Mental Health Services. This review which was endorsed by the HSE in the *National Service Plan 2024* has identified a set of recommendations that will inform the co-production of the **National Recovery Education Strategic Plan**.

The opportunities to access recovery education within Mental Health Services has grown since 2013 when the Mayo Recovery College was established. Over the last twelve years, the recovery education community has expanded to reach many services across the country. Recovery Education Services and Colleges are prime examples of working to the principles identified within our *National Framework for Recovery (2024)*; Centrality of Lived Experience, Co-production, Organisational Commitment and Supporting Recovery Orientated Learning and Practice. The Office of Mental Health Engagement and Recovery (MHER) commissioned this review to gain a comprehensive view of the current structures, processes and areas of good practice guided by our existing documentation. The report highlights what is working well and what areas of improvement will be required to ensure this service is sustained and continues to grow and thrive in the complex system we work in. The recommendations from this review will help shape the strategic development of Recovery Education Services into the new HSE landscape. The impactful testimonies and knowledge shared by those working and supporting the work of Recovery Education Services, provides an insight to the power of what is possible when co-production is a core value and the person's strengths and expertise is honoured in their recovery journey. The review spotlights key findings from the literature that supports and confirms much of what we already know about recovery education here in Ireland. It identifies a lack of information around the operationalisation of recovery colleges and I am pleased that we in the Irish Mental Health Services will be able to contribute to the evidence base to fill this gap and continue to co-produce resources to support consistency and quality services. The methodology undertaken and the array of engagement methods to capture the voices of the stakeholders has produced a rich and reflective report with important recommendations to continue to develop recovery education in our Mental Health Services. In reading this report you see many areas of good practice as well as areas for further development and improvement.

I would like to thank the review team, Catherine and David, Fiona and the MHER Team, Heads of Services, staff working in the Mental Health Services and Mental Health Ireland for your contributions to and support of this review.

A special thanks to the dedicated teams who work and volunteer across the Recovery Education Services and Recovery Colleges for their commitment, passion and belief in the work they do and holding the hope for all who attend the programmes, and for being the proof that recovery is a real possibility for anyone experiencing mental health challenges. In response to this review, the HSE and the office of MHER are committed to continue working towards our strategic plan in line with *Sharing the Vision* and Sláintecare to establish and embed a Recovery Education Service that we can all be proud of and will ensure we strive to continue to enhance the recovery orientation of our services. In doing this we provide real recovery opportunities to those using our services.

Michael Ryan

Glossary of terms

A National Framework for Recovery in Mental Health was first published in 2017 and reviewed in 2024 and acts a road map for the continuous evolvement of recovery orientated services.

Volunteer Recovery Education Facilitators have received training to co-produce and co-facilitate recovery education modules in their area. They are in receipt of out-of-pocket expenses for travel and subsistence.

Adult Education Principles are self-directed learning, prior experience, readiness to learn, problem solving, relevance and motivation. These principles are essential for designing effective adult education programmes that meet the unique needs of adult learners.

Area Leads for Mental Health Engagement seek to understand what the experience of using mental health services is like for people in Ireland to then take concrete, feasible, and practical recommendations to the Health Service Executive management teams to bring about real-world improvements to how services are provided.

ARI – **Advancing Recovery in Ireland** was a National Mental Health Division initiative that brought together people who provide our services, those who use them and their families and community supports, to work on how we make our mental health services more recovery-focused.

CHIME – A systematic literature review of over 1100 recovery narratives by Mary Leamy and Mike Slade (2O11) identified five common processes that people with mental health conditions considered essential for recovery to occur in their lives. These are Connection, Hope, Identity, Meaning and Empowerment.

CHO – **Community Healthcare Organisations** are responsible for providing care and services in a specific geographic area. Community Healthcare Services are the broad range of services that are delivered outside of the acute hospital setting and include Primary Care, Older Persons, Disabilities, Mental Health, Health and Wellbeing and Quality, Safety and Service Improvement.

Co-Facilitation – refers to the facilitation of learning that involves two or more facilitators working together in a co-operative and collaborative manner to support the learning outcomes that advance recovery. This will include people with professional and lived experience. There must always be representation of people with lived experience of their own mental health challenges and where possible and appropriate, by family members and community partners.

Co-production – an emerging space in healthcare, which involves co-planning, co-designing, co-delivering, co-receiving and co-evaluating service design and delivery between people with personal experience of using mental healthcare services patients/consumers and family/carers and people with professional expertise in mental health clinicians and other service providers.

Discovery College – this is the youth adaption of the Recovery College for people aged 12-25. It is inclusive of every young person in this age category. Co-production and workshops take place with people from the mental health services, community, and organisations that work with young people.

Family Member Experience – this includes relatives, friends and other supporters of all ages who care about and are supporting people who use mental health services during their recovery journey. Throughout the document the term Family Member will be used, it is agreed that this term will be inclusive of supporters, friends, relatives, carers, parents, sibling and children.

Lived/Living Experience – people with lived/living experience can identify either: as someone with personal experience of mental health challenges, psychological distress, substance use and/or addiction.

Longitudinal Outcome – Longitudinal outcomes measurement involves the collection of outcomes data across a continuum of care services in a patient cohort.

Mental Health Ireland aims to promote Mental Health, Wellbeing and Recovery for all individuals and communities, and works in partnership with MHER by facilitating the employment of Recovery Education Teams.

MHER – **The Mental Health Engagement and Recovery Office** (MHER) was established in 2019 by the coming together of the Advancing Recovery in Ireland project (ARI) and the Mental Health Engagement Office (MHE). ARI and MHE were the initial drivers of cultural change for the recovery approach. MHER is working to support this continuing process of change in mental health services, towards services that recognise that recovery is about individuals achieving a full life of their own choosing, building on strengths and realising goals, regardless of the presence of mental health challenges, and such a life is possible for everyone.

MOU – **Memorandum of Understanding** is an agreement between the HSE and Mental Health Ireland. It outlines the roles and responsibilities of both partners in relation to Recovery Education Service provision.

n – in statistics 'n' represents the sample size drawn from a population for analysis.

Pedagogical refers to anything related to the methods and theory of teaching. It encompasses the practices and approaches used by educators to facilitate learning and is often associated with the role of a teacher.

Peer Educator has lived, and/or family experience who is employed to manage and co-ordinate recovery education activity within a recovery service or college. A Peer Educator is a co-producer and co-facilitator of recovery education. In one area the roles are titled Education, Training and Development Officer (family role) and Peer Education, Training and Development Officer (lived experience role) but for the purpose of this review document the term Peer Educator will be used throughout. The Peer Educator provides line management to the Recovery Education Facilitators.

PLE – **People with lived / living experience** of mental health challenges.

Randomised Control Trial (RCT) is an experimental study design where the subjects in a population are randomly allocated to different groups

Recovery – has been defined as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles and a way of living a satisfying, hopeful, and contributing life even within the limitations caused by mental health challenges.

Recovery Colleges – The purpose of a Recovery College is to support people's recovery from mental health challenges through learning and education that is co-produced by people with lived experience, family members / supporters and professional expertise. Recovery Colleges aim to provide a safe place for people to learn new skills (and expand on existing skills) together, which helps to increase their connection with others, and their sense of control over their lives. Emphasis is placed on people's talents and strengths, with the aim of inspiring optimism. Students are encouraged to consider their opportunities for the future, creating a culture of personal empowerment and an underlying feeling of hope.

Recovery Co-ordinator – is a person who is employed to support the direction, management and running of a Recovery Education Service. In one area this role is referred to as the Recovery Education Manager but for the purpose of this review document the term Recovery Co-ordinator will be used throughout.

Recovery Education – Recovery Education is the process by which individuals explore, assimilate and create the knowledge required for recovery in their own lives or in the lives of those they support. It involves providing educational services to, and within, local communities It is based on an adult education approach which offers the choice to engage in learning opportunities. It is underpinned by the values of self-direction, personal experience, ownership, diversity and hopefulness.

Recovery Education Facilitators – have lived and /or family member experience who work in a Recovery Education Service or Recovery / Discovery College to support the co-production and co-facilitation of recovery education modules. They are line managed by and work with peer educators.

Recovery Education Service is an educational approach that empowers individuals with mental health challenges, their families, and service providers to explore, understand, and create knowledge necessary for recovery, using adult learning principles and co-production. Recovery Education Services can be delivered within mental health services and in community settings.

RHA – **Regional Health Areas** are responsible for coordinating and delivering health and social care services in Ireland. This includes the managing and organising care for people and communities in their area and ensuring care is of high quality and meets both local needs and national standards.

Sharing the Vision – A Mental Health Policy for Everyone sets out an ambitious programme for the continued improvement of Irish mental health services. It is Ireland's ten-year mental health policy to enhance the provision of services and supports across a broad continuum - from the promotion of positive mental health to specialist mental health service delivery. It builds on the significant work done over the past decade to modernise mental health services, build the workforce and invest in fit for purpose infrastructure.

Sláintecare reform is transforming how we deliver healthcare in Ireland, building towards equal access to services for every citizen based on person's need and not their ability to pay. By putting people at the centre of the health system and developing primary and community health services, the Department of Health and HSE are working together to provide new models of care that allow people to stay healthy in their homes and communities for as long as possible. The aim is to deliver the Sláintecare vision of one universal health service for all, providing the right care, in the right place, at the right time.

Social Capital is the value of social networks and resources derived from these networks that contribute to a community's wellbeing.

Introduction

HSE Office for Mental Health Engagement & Recovery (MHER) in partnership with Mental Health Ireland (MHI) have supported Mental Health Services (MHS) in many of the Community Health Organisations (CHO) and the National Forensic Mental Health Service (NFMHS) in the evolution of HSE Recovery Education Services since 2013. A Recovery College/Recovery Education Service is a HSE led and funded, mental health community facing, adult education initiative that provides peer-led, co-produced and co-facilitated learning to people with lived/living experience of mental health challenges, family members/supporters and mental health professionals. Recovery Education Services are provided into General Adult Mental Health Services, and are beginning to evolve in Child & Adolescent Mental Health Services (Discovery College) and into the community. Module and course content is co-produced and co-facilitated by people with lived experience of mental health challenges, family members, carers, supporters, service providers and community partners.

MHER commit to, 'co-produce the structures and systems that will ensure recovery education is embedded within mental health services as an objective within its strategic plan *2023-2026 – Engaged in Recovery* (HSE, 2023, p.7). This review was endorsed by the HSE in the *National Service Plan for 2024* (HSE, 2024a). MHER was established in 2019 by the merging of the Advancing Recovery Ireland project (ARI) and the Mental Health Engagement Office (MHE). The work of the MHER Office is focused on guidance and support for recovery approaches and meaningful engagement across mental health services. MHER is guided by the National Mental Health Policy, *Sharing the Vision - a mental health policy for everyone 2020-2030*, (Dept of Health, 2020), the *Sláintecare Action Plan* (Dept. of Health, 2019) which emphasises the importance of engagement, and the work of the Office is guided by the *Framework for Recovery in Mental Health* (2024 – 2028, HSE, 2024b) whose key underpinning principles are; Centrality of Lived Experience, Co-production, Organisational Commitment and Supporting Recovery Orientated Learning and Practice. This report was commissioned by MHER in June 2024 with the purpose of conducting a comprehensive review of the existing structures and processes in the delivery of recovery education within the HSE Mental Health Services. The report acknowledges that there are other Recovery Education Services in operation in Ireland but this review is specific to existing HSE funded Recovery Education Services within mental health services.

Project Aims

- To identify good examples of recovery education service provision in line with existing HSE guidance documentation and Service Level Agreement with the NGO partner Mental Health Ireland.
- To identify the best structures and processes needed to ensure that recovery education is embedded within the HSE Mental Health Services.
- To inform the Mental Health Engagement & Recovery Office in the co-production of a National Recovery Education Strategy

Project Objectives

1. To conduct a review of existing organisational structures of Recovery Education Services and Recovery Colleges within HSE Mental Health Services.
2. To produce a well-formatted, clear report and evidence of current practice in relation to Recovery Education Services and Colleges across the existing HSE Mental Health Services.
3. To summarise the evidence and provide key recommendations from a review of national and international literature addressing best practice in recovery education delivery.
4. To support the co-production of revised guiding documentation for a Recovery Education Service model to meet the needs of the developing HSE Regional Health structures.

What in your opinion works well in recovery education?

"The approach to workshops being a safe place, the discussions and sharing of tools and ideas. The fact that workshops are developed with the voices of everyone involved equally. The way it's facilitated by a mix of people with lived experience, family members and supporters, staff or professionals. It brings together things that are based in professional knowledge, has evidence to support it and the practical lived experience side makes it more real and meaningful, more inspiring in a way."

Person with lived/living experience

Background

Historically, coercive measures, institutionalisation and restraint characterised services for people who may have been experiencing mental health challenges (WHO, 2022). According to Horwitz (2012) the 1990's saw a significant upsurge in the medicalisation of everyday social life, and the emotional and psychological challenges that go with that. Sociological approaches to mental health and illness remind us that while there may be certain individual aspects to consider when understanding mental ill health, the medicalisation of emotional distress has contributed to us losing sight of the broader cultural, societal and economic factors that can impact a person's mental health. A sociological approach highlights the innate need in humans for connection, belonging and being a valued member of the community. It also considers the impact of inequality, poverty and cultural beliefs as significant factors on mental health (Horwitz, 2012). In moving away from the contextual history where the institutionalised approach to mental health once sat, recovery in mental health has been defined as:

> **"a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness"**
>
> (Anthony, 1990, p. 527)

Personal recovery in mental health and addiction is described by Slade et al. as **living a purposeful and meaningful life despite experiencing mental distress** (2010). According to Slade, (2009) recovery has been conceptualised both as **clinical recovery and personal recovery with clinical recovery emphasising symptom reduction as an outcome**.

In recent years, recovery in mental health services has become a key approach across many countries (Slade et al., 2014). Toney et al. (2018) highlight how mental health services have been orientated towards supporting recovery and that this orientation is central to national policy in various countries.

Examples include:

- *Sharing the Vision, A Mental Health Policy for Everyone 2020-2030*
- *Vision for Change 2006*
- *No Health without Mental Health 2011*, UK
- *Mental Health Action Plan 2013-2020 WHO, 2013*, Geneva
- *Changing Directions, Changing Lives: Mental Health Strategy for Canada 2012*

Recovery education is a growing feature of HSE Mental Health Services in Ireland (HSE, 2017).

To this end significant guidance documents have been co-produced in Ireland. The overarching document was *A National Framework for Recovery in Mental Health 2018-2020*, it has since been reiterated 2024-2028 (HSE, 2017; HSE, 2024b). This document was co-produced to support mental health services in becoming more recovery orientated and is underpinned by four key principles:

Four Key Principles:

1. **The centrality of lived experience**
2. **The co-production of recovery promoting services between all stakeholders**
3. **An organisational commitment to the continuous development of recovery in Irish Mental Health Services**
4. **Supporting recovery-orientated learning and recovery orientated practice across all stakeholder groups**

In regular consultation with all stakeholders, the revised framework maintained these four principles as its bedrock, though will review these again in advance of any further version after 2028 to ensure the framework stays relevant to recovery orientation at that time (HSE, 2024a). Other important documents that were co-produced to support the Framework and the development of recovery education included *Co-production in Practice: A Guidance Document 2018-2020,* (HSE, 2018a); *Family Recovery Guidance Document 2018-2020*, (HSE, 2018b); *Recovery Education Guidance Document 2018-2020* (HSE, 2018c). In addition, the co-production of two recovery education documents paved the way for a frame of reference for the development and delivery of recovery education in Ireland. ***RESOURCES*** *to Support the Development and Implementation of Recovery Education* 2020 – 2025 (HSE, 2020a) and ***TOOLKIT*** to *Support the Development and Implementation of Recovery Education 2020 – 2025* (HSE, 2020b) were to serve as reference points in delivering recovery education.

In the *RESOURCES* document, recovery education is noted as a '**key driver**' for developing recovery orientated mental health services and to empower individuals to achieve improved recovery outcomes in their lives (Ryan in HSE, 2020a. p. 5). Its aim was to provide quality assurance and to outline best practice around co-production, delivery, promotion and evaluation of recovery education. The *TOOLKIT* document provides a conceptual background around the concept of recovery education to recovery education and its close ties with adult learning and transformative learning. It provides a range of practical resources and templates to support those who deliver recovery education within Mental Health Services. The aim of this document was to ensure fidelity to the principles of recovery education and maintain a high level of quality and evidence-based practice while delivering a *Recovery Education Service or Recovery College* (HSE, 2020a).

These documents present a barometer to the fidelity, quality and best practice of recovery education in HSE Mental Health Services.

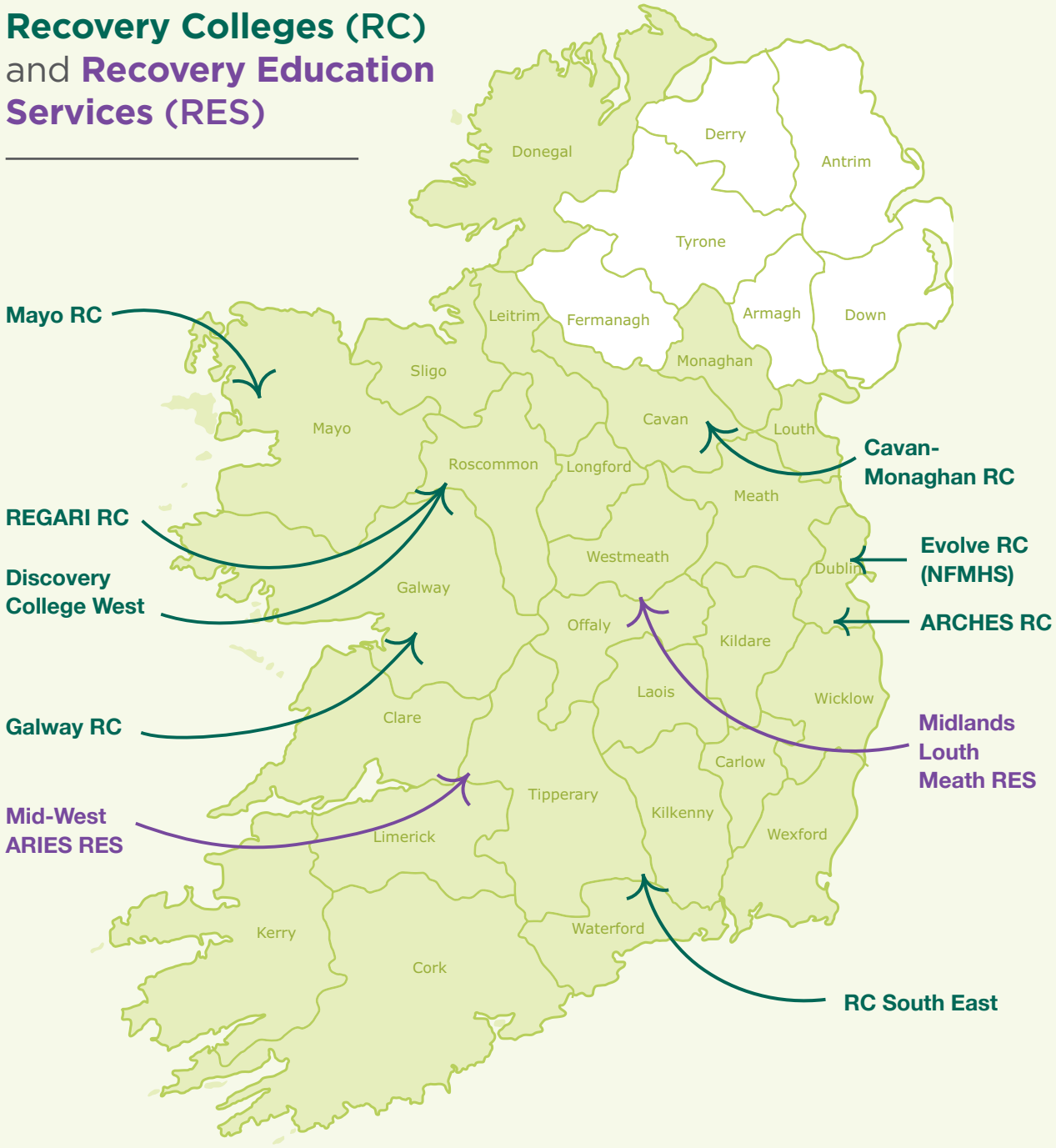
However, the launch of these two important documents came at a very critical time and their effectiveness may have been significantly hampered. The year 2019 saw the onset of the COVID-19 global pandemic and by March 2020 Ireland had entered its first in a series of national lockdowns as a response to the pandemic. The loss of personnel key to driving recovery education in 2020 was also a significant factor in hampering the communication and dissemination of the new recovery education support documents during this time. The impact of these factors played a significant role in the *RESOURCES* and *TOOLKIT* documents taking a back foot and from there they never fully got the promotional drive they required to push recovery education forward and create uniformity across the country. However, the lockdowns saw the mobilisation of recovery education move to online delivery platforms, in a pivot which, effectively saw the continuation and delivery of recovery education to a very broad audience during a time when most people were feeling the effects of isolation, fear, anxiety, loneliness and dis-connection from their social world.

This was a time indeed where **CHIME** came to the fore and became a very focused way of understanding, co-designing and co-facilitating recovery education. **CHIME** is an acronym for **Connectedness, Hope, Identity, Meaning** and **Empowerment** and serves as a framework derived from a study by Leamy et al. (2011) which identified these five components as common elements across a range of models for recovery in mental health.

Connectedness	**Feeling part of your family/community**
Hope	**Having a belief that life can and will get better**
Identity	**Having an identity in life beyond that of a person who uses services**
Meaning	**Building on strengths and skills to have fulfilling activities in life**
Empowerment	**Having the information, choice and confidence to make informed decisions on one's own life**

In 2020 the Service Level Arrangement between the HSE, MHER and Mental Health Ireland changed, and Mental Health Ireland became the employer of Recovery Education Facilitators that provides HR support to facilitate the process of recruitment of recovery education staff to work into HSE Mental Health Services. The HSE is currently undergoing a reconfiguration which sees the emergence of six Regional Health Areas across Ireland. This major transformation of the HSE will have an impact on the existing structures and services in the delivery of recovery education in Mental Health Services. It will strengthen the emergence and co-ordination of recovery services across the six regions with recovery education being a central cog in the wheel of hope, opportunity and choice for people who use and support those who use and work in Mental Health Services.

Recovery Colleges (RC) and Recovery Education Services (RES)



Literature Review

Recovery Education

Recovery education is defined as:

> **"The process by which individuals explore, assimilate and create the knowledge required for recovery in their own lives or in the lives of those they support. It involves providing recovery education services to, and within, local communities."**
>
> HSE, 2018c. p. 8

Recovery education can be delivered from a central location or hub, often referred to as a Recovery College. Alternatively, it may be available in multiple mental health service settings. This is often called a Recovery Education Service (HSE, 2020b). Recovery Colleges strive to assist individuals in their journey of recovery and help organisations to become more recovery focused (Zabel et al., 2015 p. 162). They provide an innovative approach through adult education principles and utilise lived /living experience, family member/supporters and service provider expertise in co-production to develop and deliver recovery education to support students in their personal recovery (Thompson et al., 2021). The establishment of Recovery Education Services/Colleges drives cultural change within Mental Health Services and embeds recovery orientation within service provision as well as engaging people with lived/living experience in their own recovery journey. However, according to Hopkins et al. there are significant challenges in implementing the collaborative, co-produced approach within the constraints of publicly funded mental health clinical services not least because recovery focus is not commonly a feature in university disciplines or ongoing professional training (Hopkins et al., 2023).

While there are many reported positive outcomes for recovery education, they have mainly come from audits, case studies and non-peer reviewed evaluations which pose question marks around their ability to objectively measure recovery education (Wilson et al., 2019). This literature review focuses on recovery education in terms of its development, outcomes, operationalisation and identifies best practice for implementing, sustaining and evaluating recovery education. While self-management education has been seen as an evidence-based intervention in the treatment of chronic physical illness its use in mental health is relatively new and even more recent are peer-led education programmes for recovery from serious mental health challenges (Cook et al., 2011). The concept of a recovery education centre originated in the United States in the 1990s and the first Recovery College opened in London in 2009 (Durbin et al., 2012). Since then, there has been a rapid growth. Indeed, Hayes et al., (2023) identified 221 Recovery Colleges operating in 28 countries across five continents in their cross-sectional survey of organisational and student characteristics, fidelity, funding models and unit costs of Recovery Colleges. They further suggest that at the time of the survey a Recovery College was being developed in Brazil meaning there would be a Recovery College on six continents when that opens. Unsurprisingly, a range of descriptions exist pertaining to recovery education including Recovery Education Service, Recovery Academy, Recovery Education Centre, Discovery College and Discovery Centre (Lin et al., 2023). There are 7 Recovery Colleges, 1 Discovery College and 2 Recovery Education Services in HSE Mental Health Services. This literature review will refer to recovery education when possible but will use the terms Recovery Colleges and Recovery Education Services interchangeably when contextually necessary.

Recovery Colleges and Recovery Education Services are different from clinical or therapeutic approaches in that they are based on pedagogical principles from adult education (Perkins et al., 2012). Hoban cited in (HSE, 2020b) provides insight into the compatibility of adult learning principles, constructionist theories and transformative learning with recovery, thus shining a light on the potential of recovery education in the recovery journey. **According to Knowles, (1984) adult learning principles include:**

- **Self-directed learning:**
  Adults are motivated to learn and take responsibility for their own learning.
- **Relevance and goal-oriented:**
  Learning should be relevant to their lives and work, and adults need to know why they are learning something.
- **Experiential learning:**
  Adults use their life experiences to facilitate learning.
- **Active learning:**
  Adults learn best when they are actively engaged in the learning process.

However, Jones et al. (2024) in a recent review considered this aspect of recovery education and while they highlight the acceptance of the need to integrate pedagogical principles into the design and delivery of recovery education, they cite a lack of empirical evidence around the practical use of educational paradigms such as transformative learning theories and furthermore suggest an opportunity for research in this area. Their discussion formed part of a scoping review they undertook in trying to map the operationalisation of Recovery Colleges which revolved around the broader issue of fidelity to key principles that underpin Recovery Colleges such as co-production and adult learning.

According to Toney et al. (2018) recovery colleges are collaborative, strengths based, person centred, inclusive and community focused. Additionally, a key feature is the emphasis on **co-production** which is defined as **"an emerging space in healthcare which involves co-planning, co-designing, co-delivering, co-receiving and co-evaluating service design and delivery between people with personal experience of using mental healthcare services, family/carers and people with professional expertise in mental health clinicians and other service providers"** (Hopkins et al., 2023: p. 18). Co-production ensures that individuals with lived/living experience and professional experience co-produce all aspects of the college including curriculum, quality assurance and course delivery. Generally speaking, small teams of staff with lived/living experience and mental health practitioners are employed by Recovery Colleges while occasionally additional peers, family members/supporters and practitioners collaborate on a sessional basis (Toney et al., 2018). **The defining features of a Recovery College required in order to transform both services and the lives of individuals whom they serve are**:

1) **Co-production between people with personal and professional experience of mental health challenges**
2) **Have a physical base**
3) **It operates on college principles – the student choice in selecting courses they themselves want to engage in**
4) **It is open to everyone**
5) **There is a personal facilitator who offers guidance and information**
6) **The college is not a substitute for traditional assessment and treatment**
7) **It is not a substitute for mainstream colleges**
8) **It must reflect recovery principles in all aspects of its culture and operation.**

The principles outlined in this context are, a positive welcome and environment, the use of language that conveys strong messages about the purpose of the Recovery College, and messages of hope, empowerment, aspirations and possibility (Perkins et al. 2012).

Furthermore, the Recovery College model is guided by the **values of hope, choice, opportunity and empowerment for individuals and communities**. They take enrolments for courses rather than referrals and in the process of co-production, they empower people to not only contribute but also to develop leadership skills and influence change (Yoeli et al. 2022). While Recovery Colleges collectively share a common culture and values, they differ individually regarding their operation, structure, funding and fidelity to the original model, and this impedes generalisability and comparability across evaluations. This highlights the need for further robust research to gain a better insight on the state of knowledge of the impact of the recovery education model (Theriault et al. 2020).

What does the literature tell us about Recovery Education?

The literature search accessed google scholar and CINHAL to identify and collect relevant literature. It also followed up on references identified within obtained articles to ensure a thorough search of the literature was carried out. Relevant policy and guidance documents were reviewed for inclusion and were identified through the reviewers practice knowledge. Terms entered to the search were Recovery in Mental Health; Recovery; Recovery Education; Recovery Colleges; Recovery Education Evaluations; Methodologies in Mental Health Recovery Research, Recovery Education and Organisational Change.

There is a growing body of research outlining the positive outcomes of recovery education and Recovery Colleges. However, the quality and methodological rigour of existing literature remains to be scrutinised with various authors calling for a more robust approach in evaluating Recovery Education Services (Toney at al. 2018, 2019, Theriault et al. 2020, Hayes et al. 2022). This section looks at what the literature is telling us about recovery education and what this may mean for future planning of recovery education. Cook et al. (2011) found in a randomised control trial that peer-led mental illness education improves participants' perception of recovery and levels of hopefulness over time even when controlling for severe depressive symptoms. A randomised control trial of the self-management programme, Wellness Recovery Action Planning (WRAP) found positive changes in self-management attitudes, skills and behaviours (Cook et al. 2012).

Crowther et al. (2019) carried out a systematic review of 44 publications and semi-structured interviews with 33 Recovery College stakeholders including peers, educators, students, managers, community partners and clinicians. At staff level, they found that staff experienced positive outcomes including experiencing and valuing co-production; changed perceptions of service users and changed attitude in professional practice; and increased passion and job motivation. At service level they found that recovery colleges often develop separately from their host system allowing an alternative culture to evolve providing experiential learning experiences to staff around co-production and education on a peer workforce. In short, the study argues that a certain distance between the host organisation and the Recovery Education Service is necessary if a genuine cultural alternative is to emerge. Lastly, the study found that at societal level, recovery colleges provided opportunities to learn from people with lived experience through collaborations with community-based organisations and that this may impact on community attitudes around mental health (Crowther et al. 2019).

A small-scale longitudinal study using semi-structured interviews by Thompson et al. (2021) set out to qualitatively explore how past students in a Recovery College understood the influence of the college on their recovery at one year follow up. All participants discussed gains that were made following Recovery College attendance that were sustained at one year follow-up. The study explored the experiences and perspectives of students that had attended at least one course. It aimed to tease

out what it is about Recovery Colleges that makes them effective in producing these outcomes, in other words, their mechanisms of change. Three themes emerged from a Framework Analysis of the semi-structured interviews:

1) **Ethos of Recovery, which included the environment as being supportive and inclusive and working in co-production**
2) **Springboard to Opportunities, which included supporting hope for the future, opening doors, finding balance and structure**
3) **Intrapersonal Changes, which included increased confidence and worth, empowerment, increased self-awareness**

In discussing their findings, the authors present a hypothesised model of change which suggests that the Ethos of Recovery provides a safe platform while the Recovery College serves as a Springboard to Opportunities effectively launching students in different directions depending on their individual goals. This part of the process empowers people to make healthier choices, explore hobbies and enables people to achieve better balance in their lives. The impact of the Springboard acts as a catalyst to help the student to see themselves in a different light in terms of how they see themselves and feel about themselves and creates a positive identity shift. The authors are keen to note that the model is most likely not a linear process but rather that Ethos, Springboard and Intrapersonal Change elements are a mutually reinforcing dynamic. A limitation of this study was that it was a single site Recovery College and a small, self-selected sample in the study.

A recent systematic review and meta-analysis of recovery education interventions for staff showed that recovery training activities appeared to have a clear but moderate impact on the beliefs and attitudes of service providers. Moreover, less clear was the impact on actual practice with qualitative evidence appearing to suggest organisational obstacles preventing practice change (Eiroa-Orosa and Garcia-Mieres, 2019). However, Williams et al. 2016 (cited in Hopkins et al. 2023 p. 19) suggests that **having a Recovery College offers a parallel service and a 'safe place' for practitioners to practice working in a recovery orientated way without having a sense of 'getting it wrong'**, referring to this as a parallel process.

Jones et al. (2024) timely review revealed scant literature around the operations of Recovery Colleges, in total, they found just ten primary studies that met their inclusion criteria. From these, the authors were able to surmise that Recovery Colleges were inherently idiosyncratic, adjusted to local needs, aligned mainly to the medical model in which there existed a tension and key terms like co-production or recovery were unclear. The review highlighted that while co-production fidelity studies had a consensus that co-production involved people with lived/living experience, family/carers and service providers but there was little evidence of details of how this collaborative process can be established, maintained. It was also pointed out little evidence was found relating to the processes to embed it and or respond to situations where co-production was reduced or undermined. According to Jones at al. the impact of these challenges may lead to Recovery Colleges not being fully understood or their value not being fully appreciated. Indeed, it was reported in their review that of the studies included none of them contained a consistent definition of co-production or recovery. They shed light on the lack of clarity around underlying principles which was remarkable and that the divergent interpretations may obstruct the development of Recovery Education Services and the structural factors surrounding it. It concluded by highlighting the critical need for future research to inform fidelity criteria and co-production and the structures necessary to operationalise recovery colleges successfully (Jones et al. 2024).

Toney et al. (2018) undertook a systemised review of all publications about recovery colleges. **The purpose of the review was to identify mechanisms of action and outcomes for students**. It found four mechanisms of action:

1) Empowering Environment

2) Enabling Different Relationships

3) Facilitating Growth

4) Shifting the Balance of Power

Outcomes included self-understanding and self-confidence in the student and positive changes in the students' life including occupation, social and service use. An interesting outcome was the suggestion that the people who may benefit most from recovery education were those who lack confidence, those who struggle to engage with services, those who will benefit from exposure to peer roles and those lacking in social capital. Another important feature to come from this study was the development of a co-produced change approach mapping mechanisms of action to outcome (Toney et al. 2018). An evaluation of the impact of a Recovery College on mental wellbeing showed some positive results in a pre and post survey. It found that 43 of 68 students who were unemployed at the start of the study were employed at the 18 month follow up. Additionally, self-esteem, confidence and practical skills in sustaining mental health were identified by 24 students out of 84 in total who completed the intervention (Allard et al. 2024).

In a review of research evaluating recovery education and Recovery Colleges Theriault et al. (2020) found 460 articles of which only 31 were peer-reviewed and therefore included for review. This review showed that attendance in Recovery Colleges was associated with high satisfaction among students, attainment of recovery goals, changes in service providers' practice and reductions in service use and cost. It also showed promising evidence that Recovery Colleges are associated with recovery outcomes like connection and hope. However, the review also highlighted several areas for consideration. It suggested that quantitative high-level evidence was underrepresented in the studies reviewed and recommended that it should be considered in future evaluation studies. It also shed light on the lack of research on the effects of recovery education on internalised stigma and empowerment, with the latter drawing most critique as it is a key component of recovery. The review suggests that standardised tools could be utilised to measure empowerment and reduced internalised stigma.

Other areas for evaluation would need to include the effects and needs of recovery education on friends and family of individuals with mental health challenges; the knowledge that service providers acquire from participation in recovery education, the positive effects on their attitude towards people availing of mental health services and how the shift in the balance of power affect their everyday work practice. The review concludes that **by undertaking research of this kind Recovery Colleges can demonstrate that they provide an enabling environment that meets the goals of social inclusion, reduces stigma and highlight initiatives documenting the mechanisms and benefits of co-learning and how this can be fostered** (Theriault et al. 2020).

> *"Recovery eduction needs to be more known; my own GP had never heard about recovery education - I had told her about it myself, how can it be recommended to people who need it if there isn't knowledge that it is even a thing! Having more things scheduled in the evenings for people who do work."*
>
> **Person with lived/living experience**

Another study also acknowledges **empowerment being under-evaluated as an outcome in the context of recovery.** Van Wezel et al. (2023) have designed a study which will look longitudinally at:

a) effectiveness

b) economic evaluation

c) mechanisms of action and associated fidelity

d) scrutinise the collaboration between stakeholders and Recovery Colleges in the care and support domains

In designing the study, they found that empowerment was surprisingly under-assessed in effectiveness outcomes despite empowerment being one of the key principles of the Recovery College model. In a scoping review by Lin et al. (2023) looking at how Recovery Colleges are evaluated findings showed that there are complexities to developing evaluation measures for Recovery Colleges. They argue that intended impacts of Recovery Colleges include both subjectively defined outcomes such as increased confidence and improved resilience and objectively measurable issues like hospitalisations, employment and return to school. The review suggests that there has been a rapid increase in reports around Recovery Colleges and sought to explore the reasons for such. It identified three main purposes for evaluations; Evaluate Impact at:

1) System Level

2) Course Level

3) Student Level

Only four Recovery Colleges reported consequences because of their evaluations, which revolved around improving registration, modifying course duration, refined curriculum, committee processes and improvement of outreach efforts. The study concluded that there is a developing field that is exploring a range of evaluative approaches but that few appear to be co-created – a core concept of any Recovery College. According to the study, it suggests that while most studies referenced co-design/co-production very few described to what extent and how meaningfully people with lived/ living experience were involved in evaluations (Lin et al. 2023). According to Lin et al. (2022) there is **promising evidence recovery education approaches reduce hospitalisations, produce positive outcomes for personal recovery and are more cost effective than traditional mental health services**. While acknowledging the need for more rigorous evaluations the authors also refer to the challenge of cocreating an evaluation that meets the student perspective and values and is scientifically sound. This is a point developed by van Wezel et al. (2023) who demonstrate the validity and value of collaborating experiential knowledge in science with recovery education students thus reducing the gap between research and practice leading to research that is practical and scientific. They conclude that traditional quantitative methodologies alone are unsuitable in understanding which aspects of the Recovery College model are affective, for who and in what context given the rich possibilities for students created in the ethos of recovery education and Recovery Colleges (van Wezel et al. 2023).

A review by Whish et al. (2022) yielded results consistent with previous studies and suggested that **much of the impact from a Recovery College lies within its ethos of promoting empowerment and inclusivity**. It also highlighted lesser explored aspects of Recovery Colleges such as how students understand the support on offer and how expectations are managed. Horgan et al. (2020) found that expert by experience involvement in nurse education demonstrated benefits and enhanced understanding of recovery focused practice as well as better interpersonal skills. It also found that nursing practice is likely to benefit by focusing efforts on supporting experts by experience in mental health nurse education (Horgan et al., 2020). In a longitudinal outcome evaluation of recovery education for adults transitioning from homelessness in Toronto, Durbin et al. (2021) acknowledge the promising outcomes for recovery education but draw attention to the scarcity of research on recovery outcomes for hard-to-reach populations participating in recovery education. Their quasi-experimental study compared 12-month recovery outcomes of adults

enrolled in recovery education with histories of mental health challenges and homelessness to those of participants of other community services for the homeless population. The main outcome measured was a change from baseline to 12 months in self-perceived personal empowerment using the validated Rogers Making Decisions Empowerment Scale (Rogers, Chamberline & Ellison 1997). The study found that those with 14 or more hours of recovery education participation had significantly greater improvements in perceived empowerment than control group participants. It also found some qualitative improvements in health and wellbeing, self-esteem and confidence, interpersonal skills and goal orientation. The study summarises that there may be a minimal level of recovery education exposure to achieve key recovery outcomes (Durbin et al. 2021).

Other findings to emerge from the current literature include Hayes et al., (2024) who developed a typology based on organisational characteristics, fidelity and funding. It found that most Recovery Colleges scored high on fidelity to the core characteristics and principles of the recovery college model. It also alluded to the reality that many Recovery Colleges have unpaid staff in core roles, and these were mainly colleges with no annual budget. Many have various disciplines employed and most were affiliated with statutory services (Hayes at al. 2024). Toney et al. (2019) emphasise twelve key components of Recovery Colleges through doing a literature review, expert consultation, and semi structured interviews with managers. Of the twelve components, **seven were deemed nonmodifiable:**

1) Valuing Equality
2) Learning
3) Tailored to the Student
4) Co-production of the Recovery College
5) Social Connectedness
6) Community Focus
7) Commitment to Recovery

Five modifiable components were:

1) Available to All
2) Location
3) Course Content
4) Strengths Based
5) Progressive

It concluded that co-production and adult learning should be the highest priority in Recovery Colleges. They also suggest that the creation of theory-based and empirically evaluated developmental checklists and fidelity measures for Recovery Colleges will inform decision making by people with lived/living experience, family and carer members, clinicians and commissioners as well as enabling formal evaluations of their impact on students (Toney et al. 2019).

As mentioned above, Toney et al. (2018) developed a change model to establish the relationship between fidelity to the original Recovery College model, mechanisms of action and recovery outcomes. The ***RECOLLECT*** *study, a five-year programme 2020-2025*, will provide the first rigorous evidence on the effectiveness and cost effectiveness of Recovery Colleges in England to inform their prioritising, running and commissioning. This is perhaps a very positive development in the evolution of Recovery Colleges and Recovery Education Services and while much of the literature stems from the UK and many Recovery Colleges operate there it may be a future direction to think about a fidelity measure for Ireland. For instance, van Wezel (2023) outlined above, are in the process of developing their own Dutch Fidelity measures and highlight how subtle cultural differences need to be addressed. In saying that, it is striking that the difference in culture they refer to is that most Recovery Colleges/Services in the Netherlands are 100% peer led as opposed the underlying principle of co-production both in the UK and Ireland.

Recovery Education in Ireland

It is perhaps promising that the *Programme for Government 2025* declares, **"This Government will expand the Recovery Colleges initiative nationwide"**, (Gov.ie, 2025, p. 96). Similarly, a commitment to continue the implementation of the MHER Strategic Plan outlined in the *HSE National Service Plan 2024* may bode well for recovery education in Ireland as it endorsed, **"a review of Recovery Education structures"** (HSE, 2024a, p. 32).

The first Recovery College opened in Mayo in 2013 and since then 7 others have emerged including the Evolve Forensic Mental Health Recovery College, Discovery College West and two Recovery Education Services. The Mental Health Act 2001 paved the way for the recovery movement to take hold, effectively putting an end to institutionalised care to a more recovery orientated service (Irish Statute Book, 2001).

A Vision for Change 2006 emphasised the involvement of people with lived/living experience and family member/supporters in the recovery approach (Dept of Health, 2006). To support and progress recovery the HSE sought expertise from *Implementing Recovery through Organisational Change* (Imroc) to build capacity and under the guidance of Julie Repper and Geoff Shepherd from 2013 to 2017 the **10 Imroc challenges for organisational** change formed the basis of a structured programme to build service readiness and lived/living experience capacity to achieve the goal of a more recovery focused mental health service (Imroc, 2024). At this time, **Advancing Recovery in Ireland (ARI)** was a National Mental Health Service initiative that brought people together who provide mental health services, those who avail of them, their families, carers, supporters and community networks to work on how to make mental health services in Ireland more recovery focused. Nationally, ARI has now merged with the Office for Mental Health Engagement to offer a more connected service within our Mental Health Services (HSE, 2024d).

An evidence base is emerging in Ireland according to a review by O'Brien et al., (2024) who conducted a co-created multimethod evaluation of recovery education. This was a collaborative study between University of Galway, Department of Nursing and Midwifery University of Limerick, MHER, Mental Health Ireland and focused on several Recovery College sites in the West and South-East of Ireland. This evaluation used interviews, focus groups and quantitative surveys and included recovery education facilitators, peer educators, recovery coordinators and practitioner/service providers in its data collection.

Main Study Objectives

As a topic guide the study drew on the four characteristics outlined earlier Toney et al., (2018); Theriault et al., (2020) Hayes et al., (2024)

1) Empowering environment
2) Co-production - enabling different relationships
3) Facilitating personal growth
4) Outcomes for changes in students

According to O'Brien et al., (2024) findings from the study highlighted the positive impact of recovery education for all stakeholders. Positive outcomes emerged for both the Recovery Knowledge Inventory and Recovery Assessment Scales. Findings from the qualitative element of the study showed a sense of belonging, a sense of student voices being heard, positive connections to peers, and empowerment for growth. High levels of co-production were also reported in every college that participated including good opportunities to Co-produce. The focus groups also revealed evidence that learning is spread across stakeholder groups but that access to recovery education is not equitable for practitioners/ service providers. Indeed, the study highlighted a need for existing recovery education to be further embedded and promoted within formal structures of mental health services. It suggested that increased awareness and recognition of recovery education through accredited time protected training for staff would go some way to meeting this.

Recommendations from the study highlighted the need to be mindful of the issue of remuneration, equity and support for volunteers for co-production participation. In addition, it recommended that future research could focus on the barriers accessing recovery education amongst stakeholders and how these barriers may be overcome. The study concluded by highlighting barriers to recovery education and how they revolve around the need to communicate more clearly around strategic direction; national support and organisational commitment; commitment and coordination to create and implement national policies on support and volunteering. It also highlighted the concern of many within the study both staff and students around the sustainability of Recovery Education Services (O'Brien et al., 2024). The study was limited by the small scale of the project capturing just two Community Healthcare Organisations (CHO) out of nine which needs to be considered when contextualising the findings. It suggests that further large-scale research is required to strengthen the evidence in relation to best practice in recovery education as well as highlighting the benefits of recovery education and co-production in larger populations (O'Brien et al., 2024).

An earlier review of recovery education in Ireland mapped existing evidence around recovery education with a view to developing an evaluation plan which will help embed a systematic way of monitoring recovery education. ***Just Economics*** (2020) reviewed the current literature and analysed the evaluation processes and methods across recovery college sites in two CHOs in Ireland CHO5 and CHO2. In total 2047 forms were analysed including both quantitative and qualitative information. The review reported positive outcomes and student satisfaction, it also reported on another area, CHO3 in that outcomes were highly scored against the five components of the theoretical CHIME framework. However, as stated earlier in the literature, these outcomes, while promising, need to be supported by more robust evaluations going forward. One of the main recommendations advanced here was the development of a new online system of data collection that can help improve the quality and ease of data gathered. They also outline a range of questions to ask for all stakeholders for the purposes of measurement and evaluation of recovery education. In conclusion, the review highlights the positive outcomes reported from the recovery colleges involved but emphasises the substantial scope for improvement in future evaluations (Just Economics, 2020).

Another report from an Irish perspective was that of Dublin North/North-East Recovery College (Kenny et al., 2020). This mixed method report sets out its Proof-of-Concept in pioneering its evidence base. It undertook three strands in its approach to this aim; Course Evaluation; Focus Group Research; and College Evaluation. The report suggests there is clear evidence that the recovery college is an established framework providing transformative education within the community that impacts positively on students' recovery. Additionally, attendance helps students achieve self-identified goals and needs. Similar to previous studies, the college also provides a safe, inclusive and empowering environment where peer support is encouraged. Likewise, a recovery orientated environment was found to be present and when this environment was explored through the lens of CHIME, recovery outcomes were found to be highly positive (Kenny et al., 2020).

> *"The purpose is to build a sense of empowerment, confidence, self-esteem, belonging, feeling valued because of your lived experience."*
>
> **Mental Health Ireland management**

Key Findings from the Literature Review

- Recovery education is growing internationally, and Recovery Colleges have expanded across the world
- Many positive findings have been reported in the literature across a range of recovery outcomes
- Co-production, Adult Learning Principles and Recovery Ethos are core underpinnings of Recovery Colleges/recovery education settings
- There is a dearth of literature around the operationalisation of Recovery Colleges
- Developing fidelity criteria in recovery education approaches may make it easier to evaluate the operationalisation of recovery colleges and recovery education
- There is a need for more robust research evaluations of recovery education

> *"MHER should be leading on the standardisation of the structure and framework of recovery education with inbuilt robust evaluation."*
>
> **Recovery Education Facilitator**

Methodology

This review was undertaken using a mixed methods approach to gain a comprehensive picture of the structures and processes, areas of good practice in line with HSE guidance documentation and Service Level Agreement with the NGO partner Mental Health Ireland and to inform a national strategic plan for recovery education in mental health services in Ireland. In this section of the report, we focus on the recruitment of participants, the design of the review, the ethics and confidentiality underpinning the review, how the data was collected and reflexivity which kept the authors aware of our own bias in interpreting the data.

Participants and Recruitment

A total of **240** participants took part in this review. Purposive sampling was used to recruit participants who were identified through the MHER Office for participation in the review. In following this process, we ensured that all participants had exposure to, had engaged in or had knowledge and experience of recovery education in mental health services.

An online mixed-methods survey was designed for those who had been or currently are students of recovery education and/or volunteering in Recovery Education Services. A total sample of ***n165*** participants took part in the online survey and provided responses to 12 quantitative and 5 qualitative questions relating to their experience of participating in recovery education.

One-to-one semi structure interviews consisted of ***n41*** participants who were from across the following. HSE Management & Staff ***n10***, Staff from Mental Health Ireland ***n5***, Peer Educators ***n8***, Recovery Co-ordinators ***n8***, Recovery Education Facilitators ***n10***. A total of five focus groups from MHER, Mental Health Ireland, Peer Educators, Area Leads and Recovery Education facilitators were also held with a total of ***n18*** participants.
A total of ***n16*** participants took part in an online qualitative questionnaire and included Recovery Co-ordinators, Peer Educators, Recovery Education Facilitators, HSE staff, HSE Area Leads, HSE Managers, co-producers and co-facilitators.

The Office for Mental Health Engagement and Recovery led in the recruitment process for the one-to-one interviews and focus group participants through a communication to gather contact details for potential participants. This was done through the Recovery Co-ordinators, HSE Management group and Mental Health Ireland. The reviewers then followed up through direct email contact. Surveys were advertised and promoted through the Recovery Co-ordinators and included both a digital link and QR code. A printable paper and pencil version of the recovery education participant mixed methods survey were also made available, and these anonymised surveys could be returned to the Recovery Co-ordinators or recovery colleges in a sealed envelope signposted for the attention of the reviewers.

The reviewers strived to design a selection process that was representative of the spread of stakeholders across the country based on area but it also needed to be realistic and achievable. Given the large numbers of Recovery Education Facilitators, it was not viable to interview all of them and so a selection of 25% were selected for one-to-one interviews, 25% selected for focus groups. This was done via a lottery draw by writing the initials of each participant on a piece of paper. Folding these and putting them into a hat. The reviewers then picked the names out and these formed our random sample for both one to one interviews and focus group interview. Using the same process but because the numbers were not as great, 50% of Peer Educators were selected for one-to-one interviews and 50% were invited to participant in a focus group. 100% of Recovery Co-ordinators were selected as they total 8 members as a group. To gather the broader perspectives of recovery education in mental health services, a self-selected sample from Heads of Mental Health Service, Senior Managers, Areas Leads, Clinicians, Staff supporting co-production and co-facilitation and Mental Health Ireland were offered a number of choices to participate including one to one interview, focus group or qualitative questionnaire.

Design

This review utilised a cross-sectional mixed-methods approach. Surveys and focus group/interview schedules were co-created between the reviewers and questions were informed by the literature review, the objectives of the review and the *TOOLKIT to Support the Development and Implementation of Recovery Education* (2020). The reviewers also drew on their own lived/living and professional experience of recovery education and HSE Mental Health Services. The online Recovery Education participant survey was developed using Microsoft Forms and consisted of an informed consent process. There was a total of seventeen questions (12 quantitative, 5 qualitative) relating to experience and views of recovery education and co-production, benefits of what was working well and what improvements need to be made. This participant survey took between 20 and 30 minutes to complete.

The one-to-one interview schedule consisted of a brief recap on informed consent.
There was a total of 5 topic areas:

1) Recovery Education Experience

2) Purpose of Recovery Education

3) Evidence

4) Operational Structures

5) and a final open topic question on **the future of Recovery Education Services**.

Participants were also asked if they wished to add any further thoughts before the interview concluded for a copy of the interview schedule. Interviews took between 60 and 90 minutes.

The focus group interview schedule consisted of 2 main topic areas:

1) Experience of Recovery Education Services

2) Sustaining recovery education with a final open topic question.

All one-to-one interviews and focus groups took place using the online platform, Zoom. Focus groups lasted for approximately 60 minutes.

The qualitative survey was developed using Microsoft forms and consisted of 16 questions mirroring those used in the one-to-one interview schedule.

Ethics

The purpose of this review falls under service evaluation and improvement, therefore formal ethical approval was not required (HSE, 2024b). The reviewers were always mindful and empathetic with all participants in this process and best practice regarding informed consent was followed.

All participants were informed prior to taking part in the study via an information sheet and consent form as to the purpose of the review, what their involvement would require, how the data would be used and the dissemination of findings. The participants were given the option to withdraw at any time of the review, this was highlighted in the information sheet prior to the review, clearly stating that the survey or interview or focus group is anonymous and confidential.

Confidentiality

All details and the information provided in the review is stored safely, securely, and confidentially. All data is handled in accordance with Article 6 and 9 of the General Data Protection Regulation 2016 and participants have the right to request access to a copy of their data. Data in the review is managed by the review data controller Catherine Brogan Consultancy.

The data provided during the review is stored using a coding system to maintain confidentiality. Destruction of data will take place following 2 years from the final publication of the report on the review of recovery education in mental health services. All hard copies of data and forms with identifying information will be held by Catherine Brogan Consultancy and stored and destroyed in line with the HSE research policies. Digital files, without any identifying information, will be hosted on a secure cloud-based system (One Drive). We will not publish names or any information that could identify participants in any reports or publications arising from the review.

Data Collection

For this review Braun and Clarke (2006) Reflexive Thematic Analysis, six step model was deployed. Themes were identified by means of an inductive and deductive approach allowing for the generation of themes identified in the literature while also accounting for the emergence of new themes. The coding was also analysed in a latent manner with interpretative views, theories and not just in a semantic description of what the participant said. The focus groups and semi-structured interviews were recorded at the consent of the participants. This allowed for the content to be listened to, transcribed, reviewed and analysed for themes to be drawn out. Reviewers became familiar with the qualitative data by reading the transcripts adequate times, enough to be understood by the reviewers who immersed themselves in the data. Because of the large amount of qualitative data, the reviewers divided the thematic process up whereby one reviewed semi-structured interviews and one reviewed focus groups, qualitative survey responses and participant qualitative survey responses. Themes emerged from reading the transcripts line by line, intently identifying codes which consist of words, comments, quotes and opinions that related to the objectives of the review and the literature. This process required the use of rough work on sheets of paper in order to organise the large volume of data collected. When the reviewers were satisfied that they had analysed all transcripts adequately, these codes were typed into a template that the reviewers designed to support the coding and theming process and make the process more presentable in the final report. Once the reviewers were satisfied that they had identified all relevant codes from the transcripts the codes were then analysed and categorised into broader themes. Each theme was assigned its own colour using colour highlighters which allowed the reviewers to colour code sections of data within the transcripts that corresponded with the emerging themes. This was carried out in the reviewer's own time and to ensure fidelity to the objectives of the review and to cross check each other's interpretation of the transcripts and the process of how themes were drawn, the reviewers met once a week on Zoom and once a week in person during the transcription and analysis part of the review. The analysis process was monitored by regular communication by phone calls and emails. In-person meetings focused on identifying emerging themes and sub themes and categorisation. The final step was to present and discuss the findings in the context of the aims and objectives of the report including linking the outcomes to the literature presented above.

Reflexivity

Reflexivity is an important part of the research process and refers to the researcher turning the lens back onto oneself to recognise and take responsibility for one's own presence within the research and the effect that it may have on the setting and people being studied, questions being asked, data being collected and its interpretation (Berger, 2015 p. 220). The authors maintained the reflexivity process throughout the review through a number of measures that ensured potential personal and professional bias was highlighted, discussed and therefore minmised in its capacity to influence the collection, analysing, interpreting and reporting of data. There were regular meetings held with the Engagement & Recovery Programme Manager to discuss progress, process and emerging themes of the review. This ensured that the reviewers stayed on point and that the aims and objectives were clearly understood throughout the lifespan of the review. Reviewers also frequently posed the question to each other if they were indeed following what the evidence was saying or if and how much a role their own bias may have been playing when interpreting the data.

I'd love to see recovery education up in lights. Everyone being able to access it. It's part of everyone's care plan. Staff are bought in and understand it and know we are not there as a threat. It's just common sense.

Peer Educator

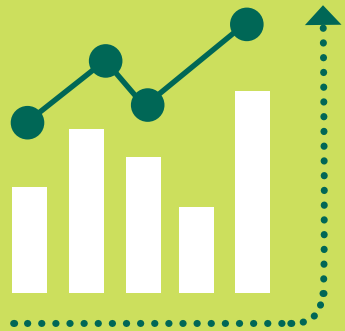
Unless the services see the research on recovery education they won't value it. You need to report on the outcome that's being achieved to understand the return on investment.

Senior HSE Manager

The Government and HSE would save a lot of money if they invested in Recovery Education Services.

Peer Educator

Findings



Recovery Education Participant

Quantitative Survey Results

N165 participants took part in the mixed methods survey with an average response time of 37m. Questions other than those related to consent were not mandatory. Some questions included an option of 'tick all that applies to you' which may be seen as the total number of participants was greater than ***n165***. Of the ***n165*** participants, ***(n104)*** identified as being as a person with lived/living experience of mental health challenges, ***(n36)*** as a family member, ***(n20)*** as a supporter/friend, ***(n22)*** as a community member, with ***(n31)*** identifying as other.

Q1. Awareness of recovery education

All ***n165*** participants answered about their awareness of recovery education. The majority ***n157*** said yes, they had heard about recovery education, ***n7*** said no and ***n1*** were unsure. When asked, have you heard of Recovery Education Services, out of ***n164*** participants, ***n151*** said yes, ***n8*** said no, and n5 were unsure. Similarly, out of ***n165*** responses, ***n152*** said yes, they had heard of a Recovery College, ***n10*** said no, and ***n3*** said they were unsure. The responses that were unsure relate to variations in language or understanding of terminology or the function of recovery education/services/colleges. This point is reflected in the literature relating to fidelity criteria and the challenges that variations in terminology, understandings of recovery and co-production give rise to when designing methodologies to measure recovery education outcomes and operational practices. It may also contribute to how various stakeholders [mis]understand recovery education and how it is seen by the wider community. A large proportion of the ***n163*** participants, ***n127*** had attended Recovery Education Services at some stage in their life, ***n34*** did not attend and ***n2*** preferred not to say.

From a select all that apply ***n121*** participants indicated that there were a variety of Recovery Education Services that participants identified as having attended, participants were asked to identify the most recent service they have engaged with, please see Table 1 below. From ***n127*** responses, the majority of participants ***n70*** had attended in person, ***n15*** had attended online and ***n42*** had attended in a blended mode of both in person and online.

TABLE 1

Breakdown of the most recent Recovery Education Service participants have engaged with	
Mayo Recovery College	16
Galway Recovery College	7
REGARI Recovery College	17
Mid West ARIES Recovery Education Service	2
Recovery College South East	8
Arches Recovery College	30
Midlands, Louth, Meath CHO Recovery Education Service	15
Evolve Recovery College	8
Other	18

Q2. Who facilitates recovery education?

Participants were asked who facilitates recovery education, from a select all that applies list (see Table 2). From ***n161*** responses, the majority, ***n103*** indicating Recovery Education Facilitator, ***n92*** identified people with lived experience, ***n86*** indicating Peer Educator. ***n48*** indicated that all available roles facilitate recovery education. This is an interesting finding as it poses a question around co-production and co-facilitation. If we take the figure of 48 who chose the option that recovery education is facilitated by all of the above, it represents less than a third of overall respondents. It may point to low staff involvement in their respective area of recovery education therefore affecting the process of true co-production and co-facilitation. This aligns with the literature, in particular, O Brien et al, (2024) in terms of the ability of staff to get involved in recovery education and how organisational commitment is key to accommodate this, therefore increasing activity in co-production and co-facilitation.

TABLE 2

Participant responses to: Who facilitates recovery education?	
People with lived experience	92
Nurse/s	37
Occupational therapist/s	26
Social worker/s	38
Psychologist/s	29
Family member/supporters	45
Doctor/s	15
Peer Educator	86
Recovery Education Facilitator	103
All of the above	48
Other	4

Q3. Have you heard of co-production?

When asked if they had heard about co-production, out of ***n164*** participants who answered, ***n120*** said yes, ***n39*** said no, and ***n11*** were unsure. When asked if they had ever been involved in co-producing recovery education modules ***n78*** said yes, ***n75*** said no, and ***n11*** were unsure.

Q4. What do you think needs to be improved?

When asked what participants felt needed to be improved from a select all that apply list see Table 3. ***n159*** participants answered this question, with letting people know about recovery education in your area being the top improvement area ***n105***, secondly, more information about how to access Recovery Education Services ***n79***, and thirdly, more recovery education staff ***n76***. These findings reveal a pressing need for increasing awareness and understanding of recovery education in communities, Mental Health Services and all stakeholders. This could be achieved through strategic communication and promotion initiatives both internally to Mental Health Services and externally in the wider community. Findings here also raise the practical need for increased staff and resource supports in recovery education.

TABLE 3

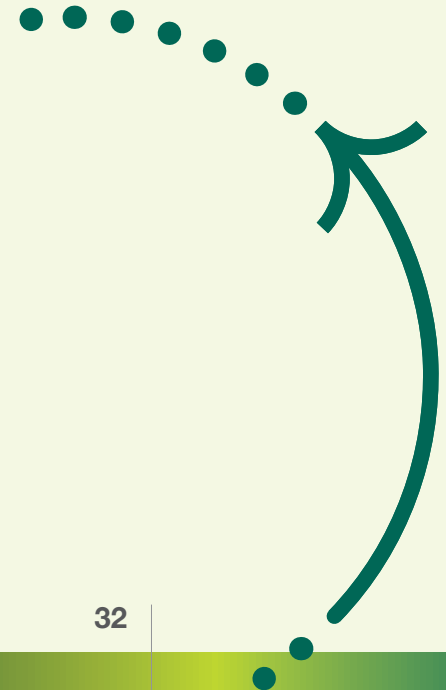
Participant responses to: What do you think needs to be improved?	
Letting people know about the recovery education in your area	105
Information on how to access Recovery Education Services	79
More recovery education staff	76
Information on what recovery education is	68
Venues where recovery education takes place	67
Opportunity to become a Peer Educator	56
More volunteers	53
More opportunities to take part in co-producing modules	51
More face-to-face modules	50
Having more time to attend	38
More online modules	28
More modules	27
Other	19

Q5. Who is recovery education for?

When asked who is recovery education for, out of ***n164*** participants responded, with the vast majority of participants believing that recovery education is for a broader population reach (see Table 4 for a list of options provided). ***n122*** of participants indicated recovery education was for all of the above, ***n94*** for people with lived/living experience of mental health challenges, ***n78*** for family members, and ***n73*** for both staff who work in Mental Health Services and people who work in Community Services such as social prescribing, GROW, AWARE, Shine, Family Carers Ireland, or others.

TABLE 4

Participant responses to: "Who is recovery education for?"	
People with lived/living experience	94
Family members	78
Friends	64
Staff who work in Mental Health Services	73
People from the community	55
People who work in community services such as social prescribing, GROW, AWARE, Shine, Family Carers Ireland, or others	73
General public	47
All of the above	122
Other	2



Qualitative Findings

In addition to the qualitative participant questionnaires displayed below the reviewers held ***n41*** One-to-One Online Interviews, ***n16*** participants completed the Online Qualitative Questionnaire and five Focus Groups with ***n18*** people.

A striking feature of the findings from the overall qualitative data, i.e. **participant qualitative questionnaire, one-to-one semi-structured interviews, qualitative survey** and **focus groups** was the commonality amongst responses in key areas.

These include:

- **Positive personal recovery outcomes**
- **A wide array of experience and benefits from recovery education**
- **Organisational challenges, for instance, lack of organisational commitment, the need for strategic direction and leadership and the need for vastly improved terms and conditions of work for staff in Recovery Education Services**
- **A lack of a clear and visible recovery education identity**
- **A lack of understanding of the ownership of recovery education and the need to build credibility in recovery education through gathering evidence and evaluations of recovery education**

One fundamental thread that is present throughout the data is **the need for effective, clear and strategic communication both internal to services and externally into the community.**

Therefore, while there is a plethora of positive findings to celebrate a high level of achievement amongst the many recovery education champions in Ireland there is work to be done to ensure it evolves to its full potential.

Direct and anonymised quotes have been used throughout to bring the findings to life, to give meaning to participant views and responses and to provide a rationale as to how the reviewers derived their emergent themes from the transcripts and surveys in the context of the aims and objectives of the review. In presenting the survey results directly below there was little scope to interpret the responses as there was in the interviews and focus group given that responses in an online survey were written text whereas interviews and focus groups responses can be teased out further in real time. Nevertheless, survey responses were rich in data, viewpoints and experiences pertinent to the review at hand.

There should be more focus on awareness of the Recovery Colleges. GPs, psychologists, psychiatrists don't tell their patients that this is available. They are either not aware of it or they don't see the value in it. I was in the Mental Health Services for over 20 years and not one professional told me about this option. I've been attending on a regular basis, and it has helped me so much I'm a different person and better able to cope and relate to other people. The GPs needed to be offering this option as a solution especially while people are on waiting lists to be seen.

Person with lived/living experience/Supporter/Friend

Recovery Education Participant

Qualitative Questionnaires

The participant questionnaires consisted of **five qualitative questions** designed to gather the views of ***n165*** participants who had participated in recovery education within Mental Health Services in Ireland.

The questions participants were asked:

Q1 **"What do you like most about recovery education?"**
n136 responses

Q2 **"What do you think are the benefits of recovery education?"**
n142 responses

Q3 **"What in your opinion works well in recovery education?"**
n137 responses

Q4 **"What in your opinion needs to be improved in recovery education?"**
n131 responses

Q5 **"Have you any other thoughts on recovery education?"**
n108 responses

Q1 "What do you like most about recovery education?"

Participants responses to what they liked most about recovery education were broad and resulted in **six themes:**

- **CHIME**
- **Co-production**
- **Peer Support**
- **Adult Learning Principles**
- **Safe Place**
- **Personal Recovery Journey**

The data supports the literature around the basis of co-production and adult learning being fundamental in a Recovery College/Recovery Education Service. Data also showed how participants value the sense of peer support that derives from attending recovery education. All five components of CHIME were present across the responses which points to an ethos that fosters recovery.

> *Promotes hope in recovery despite diagnosis.*
>
> **Community mental health nurse**

> *The thing I like most is that everyone is equal and everyone understands each other. We may not agree about everything,but we absolutely understand each other and each other's experiences.*
>
> **Family Member**

Q2 "What do you think are the benefits of recovery education?"

When asked about the benefits of recovery education, participant responses mirrored those of Q1 above whereby CHIME, Adult Learning, Safe Space and Co-production emerged as themes. However, also extracted from the thematic analysis were four additional themes: Builds Community, Sense of Belonging, Service Development and Reduces Stigma.

> *To provide people the opportunity to have connections with those with similar experiences to offer hope, support from others and to offer empowerment and education on mental health, self-awareness and personal development.*
>
> **Person with lived/living experience**

- **CHIME**
- **Co-production**
- **Adult Learning Principles**
- **Safe Place**
- **Builds Community**
- **Sense of Belonging**
- **Service Development**
- **Reduces Stigma**

Q3 "What in your opinion works well in recovery education?"

The five themes that emerged around what works well in recovery education emphasised Co-production and Adult Learning principles. Also revealed in the data was the suggestion that Recovery Education Services were supportive, accessible and of high quality.

The five emerging themes were:

- **Supportive Environment**
- **Adult Learning and Recovery Principles**
- **Quality of Recovery**
- **Education**
- **Co-production**
- **Accessibility**

> *The ethos is inclusive and supportive.*
>
> **Family member**

> *Opportunities to learn in a non-judgmental environment.*
>
> **Community mental health nurse**

> *Accessible service, talking about lived experience, keeping it real.*
>
> **Person with lived/ living experience**

Q4 "What in your opinion needs to be improved in recovery education?"

The question around improvement in recovery education yielded themes on promoting recovery education and making it available and readily accessible to many more people. Data also highlighted the appetite amongst participants of getting involved and the need for more opportunities to do so in areas such as cofacilitation and as peer educators. Co-production featured as a theme which revolved around the need for extra resources and organisational commitment. **The four themes to emerge here were:**

- **Raising Awareness of Recovery Education**
- **Increased Opportunities for Getting Involved**
- **Increased Output and Availability of Recovery Education**
- **Co-production**

There is inequality between recovery services and within areas as some areas still do not have an active recovery education service. I would like to see a championing of Recovery Education Services in all areas to create equality. Recovery education should not be based on your postcode. People should have access to a service regardless of where they live.

Person with lived/living experience / community member

Recovery education needs to be recognised as having value within the system and resourced appropriately. The service needs to have a dual function one to facilitate recovery education modules (to all as above) and the other to be utilised as resources within MHS for all training development in order to ensure co-production and recovery values are upheld and not on the side line. It requires organisational commitment in action.

Service Provider

Q5 "Have you any other thoughts on Recovery Education Services?"

The responses to this question derived themes around the value and quality of recovery education, the need to promote it and it highlighted some of the challenges that recovery education encounters.
Three main themes to emerge were:

- **Impact and Quality of Recovery Education**
- **Awareness and Promotion of Recovery Education**
- **Organisational Commitment**

This is clearly demonstrated in these three quotes:

I can honestly say that it has been one of the best things that I have done. My partner developed a psychosis but because we were not married, I was left out of the loop in his care. I felt that I was floundering with no one caring for me. My family were frantic with worry for me. It made me see clearly the attitudes to mental illness in this country. Attending as many modules as I could was wonderful. I got support and information. The Peer Educators were great. I feel they saved my life.

Family member

Attending the Recovery College has been the best thing that I have ever done. I tried everything else, medication, therapy, but nothing has helped me more than the education I receive at the Recovery College.

Person with lived/living experience

Fantastic service – the bridge between MH services and the Recovery Education Services is where the improvements are needed.

Staff

One-to-One Interview Findings

The reviewers held *n41* One-to-One Online Interviews, *n16* participants completed the Online Qualitative Questionnaire and five Focus Groups with *n18* people.

The *RESOURCES to support the Development and Implementation of Recovery Education* document, outlined in the literature, informed the development of the topic guide used by the reviewers in gathering the qualitative data across the semi-structured interviews, focus groups and online questionnaire.

THE FIVE TOPICS:

1. The Experience of Recovery Education Services
2. Purpose of Recovery Education
3. Evidence underpinning Recovery Education
4. Operational Structures for Recovery Education Services
5. The Future of Recovery Education Services

The **Focus Group** questions focused on **2 MAIN AREAS:**

- The Experience of Recovery Education Services
- Sustaining Recovery Education in Mental Health Services

Prompting questions were utilised under each of the topic areas to help guide the process.

Semi-Structured One-to-One Interviews

TOPIC 1

The Experience of Recovery Education Services

The first topic addressed was the experience of Recovery Education Services which also considered the role recovery education fulfils.

Themes emerging in this area included:

- **Organisation Commitment**
- **Leadership**
- **Culture and System Change**
- **Co-production**
- **CHIME**
- **Lack of Consistency**
- **Connection**
- **Stigma Reduction**
- **Personal Narrative**
- **Training**

The data here suggests that for recovery education to be taken seriously and for culture and system change to happen strong organisation commitment and leadership is paramount. This will ensure a whole of service approach and recovery education can influence this change in services. For people attending Recovery Education Services, recovery education was seen as a driver for personal recovery putting the person back in control of their own recovery journey. The elements of CHIME – the social need for connection, having hope or holding hope, having a sense of Identity, having meaning and purpose in life and above all the sense of empowerment. This allows for a safe space and a hopeful environment. For people co-producing and co-facilitating recovery education having key training modules on boundaries, co-production, facilitation, trauma informed and personal narrative that is consistent across the country would strengthen evidence and the impact of recovery education.

Some narratives to support this are:

> *When recovery education is working in partnership with clinical services it becomes a more holistic person-centred services and embodies recovery, hope and partnership.*
>
> **Senior Manager**

> *Recovery education and knowledge about recovery principles signifies a culture change as people are tasked to support others in their recovery and move beyond symptoms, diagnosis and illness.*
>
> **Recovery Co-ordinator**

Participants were asked their opinion on what knowledge, skills and experience are needed to take on the role of Recovery Co-ordinator, Peer Educator, Recovery Education Facilitator or Volunteer with the Recovery Education Service/College.

It is worth noting based on the information gleaned through the review from participants who took part in the one-to-one interviews that it is clear that services have evolved, strengthened and grown over the last 5 years and the review of *RESOURCES to Support the Development and Implementation of Recovery Education* and the *TOOLKIT to Support the Development and Implementation of Recovery Education (HSE, 2020 – 2025)* is indeed timely.

Below are illustrations of what participants in their opinion suggested as important to consider when reviewing the Job Descriptions.

Recovery Co-ordinator

ELIGIBILITY CRITERIA

Essential:

- Knowledge and understanding of HSE and Mental Health Services
- Demonstrative Compassionate Leadership and Management
- Sustain a culture of co-production
- Project Management
- Understanding of Service Arrangements and Budgets
- Understanding of policy / procedures, HR
- Experience in the provision of Supervision, Line Management, mentoring
- Education skills / understanding of Adult Education Principles
- Experience and understanding of evaluation, quality assurance.
- Data collection and management
- Protect the brand and fidelity to the recovery education process
- Demonstrate understanding of process of learning styles, outcomes, aims, objectives, etc
- Strong and demonstratable Communication skills
- Understanding Bias
- Networking and relationship building
- Experience in co-production and co-facilitation
- Kindness, Compassion and Empathy
- Administration skills
- Supports and understands the purpose of Reflective Practice
- Support the services in their readiness to become recovery focussed and where recovery education fits in this process
- IT skills
- Decision maker
- Committed, passionate and tenacity
- Comfortable with unpredictability
- Identifying strengths in others
- Business Planning

Desirable:

- Clinical Background but not essential – Community Development, Youth Work, Social Care,
- Lived experience desirable but not essential

Qualifications:

- Level 8 or 9 - Education, Clinical, Community Development, Youth Work, Leadership, Management, Project Management, Senior management experience

Peer Educator

ELIGIBILITY CRITERIA

Essential:

- Trained in personal narrative, co-production, trauma, boundary management
- Knowledge of how to navigate the MHS
- Understand the purpose of recovery & recovery education
- Understanding and demonstrative experience in Adult Education
- Demonstrable experience in curricula, aims, objectives, lesson plans, Facilitation, co-production, instructional design
- Experience in building engaging workshops
- Understanding of meaningful co-production
- Proficient in using technology
- Provides support and mentorship to Recovery Education Facilitators and Volunteers
- Understanding of Quality Assurance and evaluation
- Compassion
- Strong Communication skills
- Experience working with vulnerable people
- Ability to promote and communicate the recovery education service / college
- Networking, relationship building
- Understanding of the role of MHER
- Knowledge of MHS and how to navigate

Desirable:

- Line management experience

Qualifications:

- Lived / Living Experience or Family Experience of Mental Health challenges
- Level 7/ 8 in Social Care, ETB, Education, Community Development
- QQI Training, Delivery and Evaluation
- Advanced facilitation skills training

Recovery Education Facilitators

ELIGIBILITY CRITERIA

Essential:

- Understanding of the recovery process
- Understanding of recovery education
- Understanding of co-production
- Experience of co-facilitating
- Know and understand the purpose of using personal narrative
- Knowledge and experience of technology
- Administration skills
- Empathy, kindness
- Strong Communication skills
- Strong interpersonal skills
- Support the promotion of recovery education services
- Understanding of the principles of recovery education

Desirable:

- Level 7 – Education, Community Development, Social Care

Qualifications:

- Lived / Living Experience or Family Experience of Mental Health challenges
- QQI Level 6 – Training, Delivery & Evaluation

Volunteers

ELIGIBILITY CRITERIA

Essential:

Volunteers can come from a background in using or supporting someone who uses / has used, supports someone using or works in the mental health services. People with an interest in mental health from the community. Student placements from Psychology, Nursing, Social Care are welcome. Drawn from people who attended the workshops.

Desirable:

- Peer Support Certification
- mental Health UCC programme
- QQI Level 6, Training, Delivery and evaluation

To support Volunteers:

- Clear Volunteer Policy and Procedures
- A structured training programme with a focus on recovery

When the reviewers interpreted the data that came back around knowledge, skills and experience on recovery education roles and mapped it against the *TOOLKIT* document there was a number of areas for improvement relating in particular to the recovery coordinator role. There needs to be a very clear purpose and description of the role which clearly identifies the need for experience at a leadership and management level with skills in project management, communication, understanding of mental health services, networking, innovation and an understanding of adult education principles and how these are applied in the context of recovery education. The eligibility criteria and qualifications section need more clarity based on responses from the qualitative data. There is a need for a more definitive picture of where and how the roles in recovery education have evolved and how this will inform the next iteration of the *RESOURCES* and *TOOLKIT* documents.

TOPIC 2

PURPOSE of Recovery Education Services

In this topic along with exploring the opinions of participants on what the purpose of Recovery Education Services was, the reviewers also unpacked the **challenges** and **benefits** of recovery education and what the **role of MHER and Recovery** is in relation to recovery education in Mental Health Services.

The emerging themes on the purpose of recovery education mirrored some of the themes in topic one.

- **CHIME**
- **Co-production**
- **Safe environment**
- **Self responsibility and Autonomy**
- **Confidence**
- **Self-esteem**
- **Stigma Reduction**

When this was explored and probed further the areas of **change in culture of mental health services** came to the fore again as did bringing a human rights perspective to recovery by supporting the empowerment of people to take charge of their own mental health. It applies a strengths-based approach to recovery. In bringing people who use the services, family member/ supporters and service providers together it enables that experiential adult education environment where everyone can thrive.

For example participants stated:

> *It brings a human rights perspective to recovery empowering individuals to take charge of their own mental health.*
>
> **Co-producer / Co-facilitator HSE staff**

> *To change the culture of the mental health service, the national service plan for the HSE under the mental health section says that recovery education should be made available.*
>
> **Recovery Co-ordinator**

> *Having a whole service approach includes recovery education.*
>
> **Recovery Co-ordinator**

> *It's the mix of perspectives that make the difference.*
>
> **Peer Educator**

There was a unanimous voice from participants when asked **who recovery was for?** The answer was **everybody**, people who use the services, support people using the services, staff, management and people who have an interest in mental health from the community. It was viewed that everyone needs to learn about recovery, about co-production. Recovery education brings a huge opportunity to improve the quality of Mental Health Services. When probed a bit further though asking specifically if other stakeholders would agree there was a change in responses. People felt that there can be resistance in some quarters to recovery education and its paid lip service. That staff particularly that get involved in co-production and co-facilitation really saw the benefits to recovery education. There was a feeling that recovery education could be viewed as a threat and that at an organisation level there was no understanding of it and not seen as valued added for staff time.

Themes that emerged around challenges to Recovery Education Services, focused on;

- **A lack of a national and regional leadership and structure**
- **Organisation culture**
- **Lack of visibility**
- **Ownership of recovery education services**
- **Contracts**
- **Lack of policies**
- **Lack of sustained level of funding for recovery education**
- **Services lack evidence to validate the value of recovery education**

> *Clarity around recovery education which is further confused by dual employment and management systems.*
>
> **Senior Clinician**

> *It's a really difficult job and I don't think that's recognised by either HSE or MHI – understanding how emotionally and mentally challenging it can be for a recovery educator to do the job. Like I mean we are meeting people in very distressing states.*
>
> **Recovery Education Facilitator**

TOPIC 3

EVIDENCE underpinning Recovery Education

In teasing out this topic the reviewers had several sub-questions to uncover how recovery education was gathering data, using data, translating data into evidence including how data was collected, what happens to the data collected, what outcomes are achieved currently.

Themes that emerged here were:

- **Lack of clarity on the purpose of data collection**
- **Inconsistencies around data collection**
- **No national leadership on research or evaluation in recovery education**

Improvements suggested based on these themes were the need to have a set of national standards to ensure that quality national programmes, modules and workshops are being co-produced. A national shared drive to be developed to avoid duplication of processes and waste of time and resources. Clarity of purpose in collecting data and being innovative in gathering information to support validation of recovery education as can be seen in the below quotes.

> *We need a specific evaluation tool for recovery education. This needs to be co-produced. We need longitudinal reviews. We need policies and procedures in place nationally – MHER needs to have a training on collection of data and GDPR.*
>
> **Peer Educator**

> *Are we all across the country doing the same thing? Data collection should be led by MHER but everyone has a responsibility. Need to be clear on what it's for, what is it influencing, what are we hoping to achieve? We have a lack of standardisation.*
>
> **Recovery Co-ordinator**

TOPIC 4

Operational Structures

Following on from exploring the experience participants had in recovery education, the core purpose and challenges were unpacked which led to gleaning their opinions on evidence that supported recovery education. In topic 4 the reviewers focussed on **what were the ingredients needed to ensure a good Recovery Education Service**.

Two main themes emerged:

- **HSE National Leadership and ownership**
- **A National Plan for rolling out recovery education across the country.**

Participants expressed their opinion that there was a lot of confusion around recovery education and the relationship with the external NGO partner. There was no clarity on where it sits within the Mental Health Services or who owns recovery education. There was a clear message around the need for Mental Health Services to be ready to integrate recovery education into the overall services.

> *Clarity of roles relating to HSE need to be improved. Who's doing what, when, why. Ownership and day to day operations piece.*
>
> **Mental Health Ireland**

> *The MOU is not clearly understood. The policies and procedures need to be common across all services. This is where you can drive the ethos and understanding and embedding of recovery on the ground.*
>
> **HSE Senior Manager**

TOPIC 5

FUTURE of Recovery Education Services

The final topic was asking the participants opinion on what they would like Recovery Education Services to look like in 5 to 10 years.

Key themes that emerged were:

- **A National Structure**
- **Visibility**
- **Embedded in the HSE**
- **Clarity of Ownership**

Recovery education would have a national profile and there will be recovery education available and accessible right across the country both within the mental health services but also in the community. The Recovery Education Services will be visible and have defined premises to operate from. Staff working in Mental Health Services will see recovery education as part of their role. Everyone will be clear where recovery education fits in the HSE structures. The HSE / MHI / MHER triangulation will be clear and everyone will know who is leading on and owns recovery education. GPs and other Primary Care services will be signposting people to recovery education services. Recovery Education Services will be valued and the people working in the provision of the service are supported.

> *Recovery education would be embedded in the culture of the organisation and given equal status and equal consideration in assisting people to live full lives.*
>
> **Senior Manager, HSE**

> *The service needs to be incorporated into the HSE, embedded in clinical teams, have an overarching manager. The work is informed by research, data is utilised to plan for the future growth and development of the services. Supervision and line management structure is clear.*
>
> **Recovery Co-ordinator**

> *All professionals have recovery education as a module in their training.*
>
> **Recovery Education Facilitator**

When asked **what would be needed to make this a reality,** some of the emerging themes included:

- **Role of MHER**
- **Recognition of Peer Educators roles**
- **Evidence of impact**
- **Staff integral to process**
- **Investment in recovery education**

These themes were reflected in that MHER would be in the driving seat nationally where the services are resourced and financed properly. They will be linking into the regional areas to support quality, consistency and fidelity in Recovery Education Services. Peer educator roles would need to be seen as a discipline like any other discipline in the provision of Mental Health Services. The long-term impact of recovery education needs to be captured and reported to build the evidence base to support its sustainability and growth. Mental health services staff need to have protected time to co-produce and cofacilitate recovery education and that this is seen as integral to their role.

> *What would help is the REO, National Service Plan and REO plan so that recovery education can be referred to when the service is being assessed. It needs to be visible to be audited internally.*
>
> **Senior Clinician**

Before concluding the interview, the reviewers asked the participants had they any further thoughts they would like to express.

Below are the emerging themes:

- **Standardisation**
- **Organisation Commitment**
- **Rewarding**
- **All staff to attend training on recovery**

> *Recovery Education is a critical partner and discipline in the service.*
>
> **Senior HSE Manager**

Qualitative Survey Findings

Qualitative surveys were developed for anyone who could not attend the one-to-one interviews but wanted to contribute their views to the review. Surveys were made available through an online link, QR code and hard copy, and were promoted through recovery coordinators. In total, 16 surveys were completed online. Surveys were designed around the same five topic areas as the one-to-one interviews, Experience of Recovery Education Service, Purpose of Recovery Education, Evidence for Recovery Education, Operational Structures, Future of Recovery Education. As such, responses were organised accordingly and themes extracted from these related to overall topics and prompting questions.

TOPIC 1

The Experience of Recovery Education Services

Upon analysing the completed qualitative surveys, responses for Topic 1 produced five main themes. These themes highlight people's experiences of recovery education and the highly relevant role it plays in mental health recovery and Mental Health Services. with frequently occurring terms such as relevance, humanity, fulfilling, future oriented and stigma reduction. The components of the CHIME framework featured prominently across the data, in particular connection, empowerment and identity. A wide array of skills and competencies emerged as necessary for Recovery Co-ordinators, Peer Educators and Recovery Education Facilitators which may be beneficial if aspects of job specifications are to be developed in the future.

The five themes to emerge were:

- **Relevance of Recovery Education in Mental Health Services**
- **CHIME**
- **Co-production**
- **Personal Recovery Journey**
- **Multi-Skill Set**

The following quotes reflect the above themes:

> *I don't have a good understanding on the different functions of the listed job role but would suggest that depending on the function that different competencies apply according to whether role is more managerial, administrative or facilitative/educational.*
>
> **Facilitates, Co-produces, Manager in Mental Health Services**

In terms of formal experience, I have been involved in planning, co-producing, facilitating/co-facilitating and evaluating various recovery education initiatives and workshops in the service in which I work for many years. My 'experience' of this involvement has been motivating, rewarding, educational, connects me with people and with a global sense of humanity .

(Co-produces/Co-facilitates/ Works in Mental Health Services)

Promotes better understanding of recovery and practical tools for self-care as well as opportunities to contribute to topics of interest and to resource development through co-production work. It empowers a person and their support people to be in control of their own recovery journey.

Area Lead

Allows people to recognise their own innate skills and resources and to take back control of their own recovery productivity with people who have lived experience that can relate and show them hope.

Have/Do facilitate, co-produce modules in recovery education; Are a REF, Peer Educators/ Recovery Co-ordinator

Supports hope, supports self-management and wellbeing, broadens out supports beyond clinical and situates them in life in general, shared experience of people working together, equally relevant for staff, service users and family members/supporters, acknowledges our common humanity. Challenges self-stigma, social stigma and views of fixed identity and labels.

Manager in Mental Health Services

TOPIC 2

Purpose of Recovery Education

This topic covered issues around purpose of recovery education, who is it for? benefits and challenges. Responses here pointed to recovery education as serving to address power imbalances within mental health services for instance in terms of paradigm shift and a move from overly medical to a more recovery focused service. It also suggested that recovery education plays a role in reducing stigma and enhancing personal recovery. Personal recovery CHIME, Adult Learning and Co-production were represented throughout the responses as was the view that recovery education is for everyone. In terms of challenges, there were a large volume of responses which merited several themes under the term challenges.

The resulting analysis yielded 6 themes, with 6 sub-themes under the theme of Challenges.

- **Addresses Power Imbalance**
- **Reduces Stigma**
- **Personal Recovery**
- **CHIME**
- **Co-production and Adult Education**
- **Recovery Education is for Everyone**

The quotes from participants articulate these themes and sub themes:

> *The Purpose of recovery education is empowerment, facilitates hope & reduces stigma.*
>
> **Are a Manager in Mental Health Services; Are an Area Lead**

Challenges sub-themes include:

- **Contractual**
- **Ambiguity around Roles**
- **Lack of Widespread Knowledge of Recovery Education**
- **Funding**
- **Work Conditions**
- **Structures**

Recovery education ideally should be for everyone. This should include people connected with the health service (staff, people using services, family members and supporters), but also beyond this to third level training programmes for professionals, community supports outside the health service (Gardai, teachers, etc.), schools, training colleges, universities (from a promotion perspective), and the general public to change attitudes to the experience of mental health challenges and knowledge for all to manage their wellbeing and challenges to same.

Facilitates/Co-produces modules in Recovery Education/Works in Mental Health Services

Paradigm shift from medical to recovery-oriented model wherein people have control and agency over their lives, future, and treatment outcomes. Empowering people to help themselves!

Are working in Mental Health Services

I think we have an opportunity to acknowledge our common humanity, become more hopeful and realise the benefits that accrue when we all work together...the value of peers cannot be underestimated.

Manager in Mental Health Services

TOPIC 3

EVIDENCE underpinning Recovery Education

This topic was designed to get a sense of current processes for evaluating recovery education in Mental Health Services. It also sought to establish stakeholder views on how to effectively build evidence for recovery education. Two themes emerged in relation to how recovery education is currently evaluated which highlighted a certain level of uncertainty about what data was being collected as well as knowledge of numbers and various self-reporting surveys. Three themes emerged from a variety of examples given by respondents around the type of data needed and methods to collect it such as gathering all stakeholder views, robust research, and efficacy of recovery education, impact of recovery education, longitudinal research, and narrative research. Overall, these examples gave rise to emerging themes which pointed to a need for high quality research to help promote recovery education add credibility to it and contribute to its visibility.

In total there were five themes that emerged here:
(For the purpose of clarity the authors have split these into **'current evaluation processes'** and **'how to build an evidence base'.)**

CURRENT EVALUATION PROCESSES THEMES

- **Variety of Data Gathering Processes**
- **Uncertainty around type and use of data being collected**

The following quotes reflect these themes:

> *Satisfaction sheets, Formal evaluation (for some offerings), Qualitative and quantitative data, Informal evaluation by participants…i.e. the word-of-mouth feedback outside the programme shared after the fact.*
>
> **Manager in Mental Health Services**

> *We have meetings with peer educators periodically to review the content and efficacy of the workshops.*
>
> **(Have/Do Facilitate/ Co-produce modules in Recovery Education)**

> *Numbers only I think at present .*
>
> **Have/Do Facilitate/ Co-produce modules in Recovery Education; Are Working in Mental Health Services**

HOW TO BUILD AN EVIDENCE BASE

- **Mixed Methods Research**
- **High Quality Research**
- **Measure Impact of Recovery Education across a broad range of Outcomes**

The quotes below provide examples of participant views on this topic:

Pre and post surveys. Ask what changed. Ask what one change did you make? Measure soft outcomes, social outcomes. Maybe introduce social value measurement to enhance sustainability. Gather individual stories from all perspectives and promote them.

Have/Do Facilitate/Co-produce modules in Recovery Education; Are Working in Mental Health Services

Well-designed robust research evaluating the outcomes of recovery education groups and 1:1 support. Do the research quantitatively and qualitatively.

Working in Mental Health Services

TOPIC 4

Operational Structures

This topic explored several aspects around the operationalising of recovery education such as what is needed for a good recovery education service, the role of MHER, career development, understanding and responsibilities of various recovery education staff roles and where responsibility for recovery education sits. In terms of a good service, participants spoke of the need for a clear strategy, adequate training and paid roles, funding and recovery coordinators and recovery champions. Responses were from areas where some of this exists therefore can be seen as examples of a good service but also this can be interpreted as an ideal for a good recovery education service would include these things. MHER's role was largely understood as a promotional, supportive, an advocate and coordinator for recovery education. However, findings also showed that there are some who are unsure about the role of MHER. Much of the data around career development centred on unequal pay scales, progression opportunities, supervision, boundaries, training, job specs and contracts. Responses to recovery education roles appeared to show poor understanding of these roles, within HSE Mental Health Service and within current recovery education staff. Findings showed that some of these roles are ad-hoc and inconsistent across the country. In relation to the responsibility of recovery education participants responses suggested HSE ought to have full responsibility while there was also a view that everyone should have a role in responsibility.

Across this broad topic eleven themes emerged across five distinct categories outlined below:

Structures for Good Service
- Improved Working Conditions
- Organisational Commitment
- Enablers

Role of MHER
- Quality Control
- Strategic Direction

Career Development
- Improved Work Conditions
- Work Practice
- Recruitment and Job Specification

Understanding of Roles
- Need for a better Understanding of Roles within HSE staff and throughout existing Recovery Education Staff and Stakeholders

Responsibility for Recovery Education
- HSE needs to be Responsible
- Co-production of Responsibility

> *MHER role is to help people with mental health issues.*
>
> **Working in Mental Health Services**

> *Money. Lived experience professionals - if they can get any work at all - are paid embarrassingly badly. I love my job but I only have the LUXURY of indulging it as an option because my partner earns enough to make it an option for us. I can't do it full time because the childcare I'd need for that would cost more than I would earn.*
>
> **Have/Do Facilitate/Co-produce modules |in Recovery Education; Are Working in Mental Health Services**

To support education and engagement activities through networking and learning events, to help service to adhere to fidelity of recovery education and peer models, to be innovative and promote continuous learning in recovery and engagement. To work with other departments and sectors to share its learnings of embedding innovation in a stuck system. To keep recovery relevant and central to service design and development.

Have/Do Facilitate/Co-produce modules in Recovery Education; Are Working in Mental Health Service

I am not sure all staff employed in mental health services understand differences between Peer Educators and REFs; there is a scope to create more awareness about roles and responsibilities in this area of work.

Are Working in Mental Health Services

To provide funding, clarity and resources, evidence-based research to support the work.

Have/Do Facilitate/ Co-produce modules in Recovery Education

Clear strategy/vision/buy in from MH services and management/consistency/values-based practice. Adequate staffing structure (including paid roles for PLI/supporters) with appropriate supervision. Staff roles and responsibilities are appropriate to the grade they are paid.

Manager in Mental Health Services

Need to provide standards and guidance for delivery of recovery education per the final agreed strategy, SOPs, guides etc. Need to monitor delivery across the country and RHA's. Need to offer supports to RHAs to ensure recovery education offerings are made available.

Manager in Mental Health Services

Investment in training opportunities for potential and current staff. Career progression opportunities must be available. Grade appropriate payment for responsibilities people are expected to assume. Nationally recognised career path & grade structures on Consolidated Pay Scale. This needs to be an attractive offer for potential candidates, well paid, good support structure, appeal to persons desire to work in this area.

Have/Do Facilitate/Co-produce modules in Recovery Education; Are Working in Mental Health Services

Operationally it's within the RHA. Strategically it's within the RHA, but support and strategy must come from National MHS.

Area Manager in Mental Health Services

TOPIC 5

FUTURE of Recovery Education Services

The last topic looked at participant's views and/or hopes on where recovery education might be in 5-10 years. This section also gave participants an opportunity to contribute any other thoughts they had that were perhaps not expressed in the survey thus far. The analysis revealed that people largely remained hopeful around the future of recovery education and saw the future as thriving, mainstream, more expansive and integrated. In terms of any other thoughts about recovery education, participants voiced concern around issues like securing funding, credibility, strategies, integration with services and the importance of staying true to its values and identity while being integrated into HSE Mental Health Services.

Four themes emerged here:

- **A More Integrated Service in 5-10 Years Time**
- **Credible Identity**
- **Securing Core Funding**
- **Co-production is Key**

These are illustrated in the following quotes:

Further outreach, greater peer involvement in paid professional roles and greater focus on recovery education at all levels of health service, as well as MH specific.

Area Lead

But, I do think we should be driving an agenda that ultimately 'mainstreams' recovery education across all our Mental Health Services. Otherwise it is in danger of becoming a silo in MHS provision. An integrated approach that brings all staff with us is key long term to ensuring that, from the first engagement, with services there is a narrative around recovery that is hopeful. If staff are not with us this will be an uphill battle. Credibility in the delivery of these supports and offerings is key. Hence the focus on a strong career structure, competencies and investment in capacity raising for PLE and supporters will be necessary for the mainstreaming agenda. Similar to the 7 ways in which engagement has been described in the recent MHE strategy, we similarly need to describe recovery education in all its iterations, so we acknowledge all the good work that is already taking place minus the descriptor.

Area Manager in Mental Health Services

Focus Group Findings

In total, 18 participants contributed to this review in five focus groups. Focus groups lasted between 60 – 90 minutes. There were two broad topics, Experience of Recovery Education Services and Sustaining Recovery Education, each with prompting questions to help draw out participant views and experiences. Overall, there were quite a broad range of themes to emerge. Topic 1 and 2 produced 12 and 14 themes respectively none of which were at odds with the themes to emerge from the semi-structured interviews, qualitative surveys or participant data. Indeed, they only serve to strongly support the views, experiences, insight and hopes that emerged from that data.

TOPIC 1

The Experience of Recovery Education Services

There was a mix of experience within the focus groups. Lived experience unsurprisingly featured strongly while family member/supporter was also well represented. Participants had a wide range of experience of working in Recovery Education Services in Ireland, some since its inception, some for several years and some relatively new to the area. Involvement with recovery education amongst participants developed through a range of settings and influences, for example, working with other organisations in mental health, lived and family experience, ARI, other jurisdictions where recovery education was already established, changing careers. Across all focus groups adult learning principles, CHIME, connection, hope, empowerment in particular, safe place, trust, shared learning, positive ethos, personal narrative, rewarding shone through. It painted a very positive and effective landscape of recovery education in terms of its impact and the many valuable aspects that make a difference to mental health recovery. Much of this reflects the outcomes reported in the literature review. There were many positives to emerge from the question of what's working well in recovery education. Participants reported of some areas where service improvement was visible and thriving. According to the data, there are shifting attitudes and belief systems in Mental Health Services towards mental health itself, stigma and recovery orientated approaches not least recovery education. Many other aspects of recovery education were flagged as working well, the environment of a recovery education space was deemed safe, mutual, informational and a good signpost. Robust engagement structures and processes, good co-production structures and organisational commitment were alluded to in some areas. There was frequent reference to established links with third-level institutions, the view that recovery education is for everybody and the building of activity data.

Notwithstanding the challenges in sustaining and improving recovery education in Mental Health Services, it is encouraging and reassuring to see the fundamental elements of recovery and recovery education being so strongly illustrated in the emerging themes as well as good examples of service provision in recovery education.

The nine themes to emerge from the experience of recovery education, including what's working well, were:

- Recovery Journey
- Work Opportunities
- Organisational Change
- Adult Learning
- CHIME
- Recovery Education is for Everyone
- Service Improvement
- Fostering Recovery
- Ethos of Recovery Education

> *Recovery is for everyone, managers, all stakeholders without a doubt.*
>
> Area Leads/ Focus Group

> *It's the connection, the meaning in their life, the hope, they got an identity and it's really empowering to meet and go back to their team with some snippets of information that they heard that can help get back control of their lives with their teams then.*
>
> Peer Educators/Focus Group

These are clearly described in the following quotes:

> *My own journey of mental health challenges and I was in a career that no longer matched my values and beliefs you know and I suppose caused a lot of stress and anxiety in my life and I tried recovery education and I found the education piece hugely valuable having tried other things like therapy and other groups and then I got a job working in a recovery college so from a recovery and career point of view I have come full circle.*
>
> Recovery Education Facilitator/ Focus Group

> *I have a clear picture of the landscape before recovery-oriented services, and I see the positive impact that recovery education can bring for people when it's in the mix.*
>
> MHI/Focus Group

> *I feel its shifting and the way we view recovery and lived experience, and the attitudes and belief systems are changing as well.*
>
> Peer Educators/ Focus Group

> *My lived family experience showed me how people who went through mental health challenges could see light at the end of the tunnel through the recovery college.*
>
> Area Leads/Focus Group

Having explored participant experiences of recovery education including what they thought was working well in recovery education in Mental Health Services, the reviewers focused on **what needed to be improved in recovery education** for it to become more embedded in Mental Health Services. Responses here covered several main areas, participants felt that recovery education needs to be understood better and by more people. The data suggests that recovery education in and of itself needs to establish its own identity or at least solidify it both in terms of staying true to its ethos and in terms of being better understood within the mental health service staff and the broader community. Some responses clearly identified the need for HSE staff training so that they know and understand what it is they are being asked to get involved in for instance in co-production/co-facilitation/personal narrative and what recovery education is. Other examples to support this view was how recovery education facilitators and peer educators must keep explaining their role each time they meet various staff during their work. Another area that emerged for improvement revolved around resources and by extension recruitment, staff support and training, staff working conditions, pay scales, equity of contracts, and clarity of roles. Issues raised here included basic items like materials for running workshops, promotional merchandise, in some cases an actual office to work from and to meet colleagues to co-produce modules. Some areas do not have a Recovery Education Service according to the data in this review a point advanced by several participants as unsatisfactory, sad and wrong. Organisational commitment was recognised as working well in some areas but not all areas. It was also seen as the one enabler that could make such a difference if it were to be from the top.

The three themes to emerge for improving recovery education were:

- **Resources, Staff & Work Conditions**
- **Recovery Education needs to be better Understood/Recovery Education Identity is a Necessity**
- **Organisational Commitment needs to be Prioritised**

These themes are demonstrated in the following quotes:

Training for staff in mental health services to understand co-production, personal narrative and what recovery education is.

Peer Educator/ Focus Group

Staff need to understand better what recovery education is and what recovery looks like. Staff want to get behind it but the HSE structure is underfunded so it's not a priority.

Area Leads/Focus Group

Organisational commitment is what makes the difference and there is a lack of it in some areas.

Mental Health Ireland/ Focus Group

Goes back to the view that recovery education is seen as a stepping stone for people to go back to their full lives and this is an enabler or support for this.

MHER/Focus Group

Organisational commitment is a challenge, but it is the one enabler that could change so much.

MHER/Focus Group

TOPIC 2

Sustaining Recovery Education

This topic initially asked participants about their views on how to sustain recovery education. Similar issues arose to those in the previous question about improving recovery education such as having the basics, an office space, funding, more staff, full teams and better work conditions. However, other key areas to emerge centred around strengthening co-production in terms of developing co-production teams and providing an understanding of co-production across HSE. Effective communication was seen as an important factor for promoting recovery education, clarifying its role and identity, especially with the new RHA structures which in themselves seem to be causing additional confusion and uncertainty amongst stakeholders. Building an evidence base, expansion of recovery education, consistency in approaches to recovery education, getting HSE staff to engage in co-production from department of health, accountability were all issues raised in the context of sustainability. Some of the solutions advanced were to have a national recovery coordinator, organisational commitment, raising the standard of the service, raising the credibility of recovery education through academia and evidence, a focus on training, marketing, learning sets, promotion, strong leadership and direction. There was also the view within the data that there is a strong experiential knowledge base amongst those involved with recovery education in mental health services in Ireland and that this needs to be harnessed and backed in terms of vision and direction.

Responses to the question of sustainability gave rise to three broad themes, which were:

- **The Need for Leadership and Strategic Direction**
- **Recovery Education Identity and Promotion**
- **Career Structures and Work Equity Embedded in Mental Health Services**

Maintaining relationships with services and expansion of services and a good team a full team, to have an office or a base would help us sustain it.

Peer Educator/ Focus Group

We need joined up thinking.

Recovery Education Facilitators/Focus Group

The following quotes emphasise these thematic findings:

We need to work with RHA and Department of Health and the central functions of the national office.

MHER/Focus Group

Staff need to be given time, protected time so they can take time to understand what recovery is and what recovery education is, it must be part of a long-term strategy. We need to have more than just RPPW. A basic understanding of what recovery education is and where it fits in their work and if someone comes into acute then this is where it starts.

Area Leads/Focus Group

The lack of funding is an issue, Loss of control over our budgets will be an issue. We need leadership form the top.

Area Leads/Focus Group

Co-production teams. It needs to be embedded in the Mental Health Services. There needs to be more involvement from family members, carers staff and service users.

Peer Educator/Focus Group

We need a consistent approach and coordinator at national level that coordinates and supports, it needs to expand to be available to everyone.

Peer Educator/Focus Group

Respect for people who are delivering the service.

Mental Health Ireland/ Focus Group

When asked about **where the responsibility of recovery education lies**, the HSE, MHER and Department of Health were the strongest responses to emerge. Another response emerged which alluded to the MOU as being either HR, a barrier, not fully understood, not being of any interest to HSE management teams or that it was one of two stools between which recovery education staff fall between with the other stool being the HSE. Some of the views expressed around the area of responsibility included recovery education been seen as an add on rather than an integrated part of Mental Health Services. and more structure around recovery education from the minister down to the ground. Based on participant responses these issues were deemed important in contributing to clarity and ownership around recovery education.

The three themes to emerge here were:

- **Responsibility lies with HSE Mental Health Services**
- **Responsibility lies with Department of Health**
- **MOU is not clearly Understood**

This quote illustrates these:

Responsibility lies with HSE. Basically, it's between two stools, MHI and MHER and we fall between the cracks. The Department of Health should own it. Accountability issue that belongs at national level HSE but also ownership at heads of service level and local level.

Peer Educator/Focus Group

Through further exploration of MHER the review found that coordinating and communicating information, supporting recovery and supporting people working in recovery education were responses that perhaps drew no surprise. Setting standards, developing guidance and serving as a central repository of expertise and knowledge were some of the understandings of the office. Communication from MHER was something that people felt could be improved as well as more presence of MHER on the ground.

The themes included:

- **Improved Communication**
- **Co-ordinating information and Guidance**

MHER need to communicate more, have more of a presence on the ground, and be better at responding to things. I can only speak for my own recovery service but there doesn't seem to be much regular visits or communication.

MHER/Focus Groups

This quote supports these themes:

The focus group next moved into the area of **evidencing recovery education** and participant understanding of current data collection processes in respective Recovery Colleges and Recovery Education Services. Here, the need and urgency for building an evidence base through high quality research and links to academia was prominent across participant responses. Participants referred to longitudinal outcomes, mixed method approaches, measuring efficacy and impact of recovery education, narrative research, measuring softer outcome such as quality of life and CHIME. Suggested reasons for the need for research included building credibility, highlighting the power of recovery education to staff in Mental Health Services and decision makers at Department level, satisfying people with the purse strings and developing a strategy plan. A recent co-produced study on the impact of recovery education in Ireland was referred to with a view to serving as a base upon which to build further evidence.

In terms of understanding the data currently being collected by MHER and/or across the various Recovery Education Services and Colleges there was a good deal of inconsistency and ambiguity in terms of what data is collected, how it is collected and uncertainty about what is done with data.

Participants views invariably ranged from the MHER data collection process as shocking, hard to complete, unsure if there was data collection, or that there was no qualitative data being collected. Whether this is the case or not, it is certainly a perception or view that is held for some participants in this section of the review. It was highlighted that Recovery Principles and Practice is being assessed which was seen as favourable. Suggestions of oversight of guidance documents, recovery co-ordinators leading on analysing data and decisions around what to measure for instance, content or impact or both. As can be seen from quotes below a streamlined data collection process coupled with academic endeavour may be a crucial part of any strategic way forward.

Two themes emerged here:

- **Prioritise Research and Evidence Base**
- **Establish Clarity around Current Data Collection Process**

The following quotes support these themes:

Develop an outcome tool, RPP is being assessed, we could assign someone to oversee guidance documents. Longitudinal piece, what are we measuring? Content or impact?

MHER/Focus Group

We need ongoing evaluation and feedback, mixed methods research. The national level for collecting data is shocking, it's hard to fill in and its only about numbers. We have the impact study from NUIG.

Peer Educator/Focus Group

We need to develop our strategy plan with the right people, HRB, 3rd level institutions which obviously needs to be resourced. We can try gather data now even with our current limited resources. Try get better data, qualitative data.

MHER/Focus Group

The last section focused on **the future of recovery education in Mental Health Services in Ireland**. While commitment and passion towards recovery education was evident throughout the qualitative data collection process responses here really highlighted the high esteem in which recovery education is held amongst the participants. Although this cannot be generalised to the broader cohort of stakeholders involved in recovery education in Ireland it is a hint perhaps of the success of the recovery education movement thus far in its evolution in Ireland and testament to all of those who have brought it to here. The next part of this evolution is yet unwritten however it is hoped that this review may lend itself to realising the sentiments and wishes expressed in this last question of where you see recovery education in 5-10 years and final thoughts on the subject.

There was a little caution expressed, namely, being conscious of putting too much structure on it while maintaining the ethos of recovery education. Accreditation without losing the essence of recovery education. There was hope that recovery education would not get stigmatised within a sector and rather be seen as integral to that service. Participants expressed a desire for a more integrated service, out of hours recovery education, organisational commitment, part and parcel of services and access for everyone. Communication was seen as essential in addressing the lack of understanding of recovery education while visibility was linked to this and establishing and identity for recovery education. A one-word response perhaps encapsulated the underlying catalyst and motivation of all efforts in establishing and enhancing recovery education in Mental Health Services and that was **Recovery**.

The themes to emerge here were:

- **Structure and Identity for Recovery Education**
- **Availability and Access for All**

Recovery education integrated with engagement & recovery education available to everyone and that service providers see their role in that. Would like it to be part and parcel of the services and that it is valued and purposeful.

MHER/Focus Group

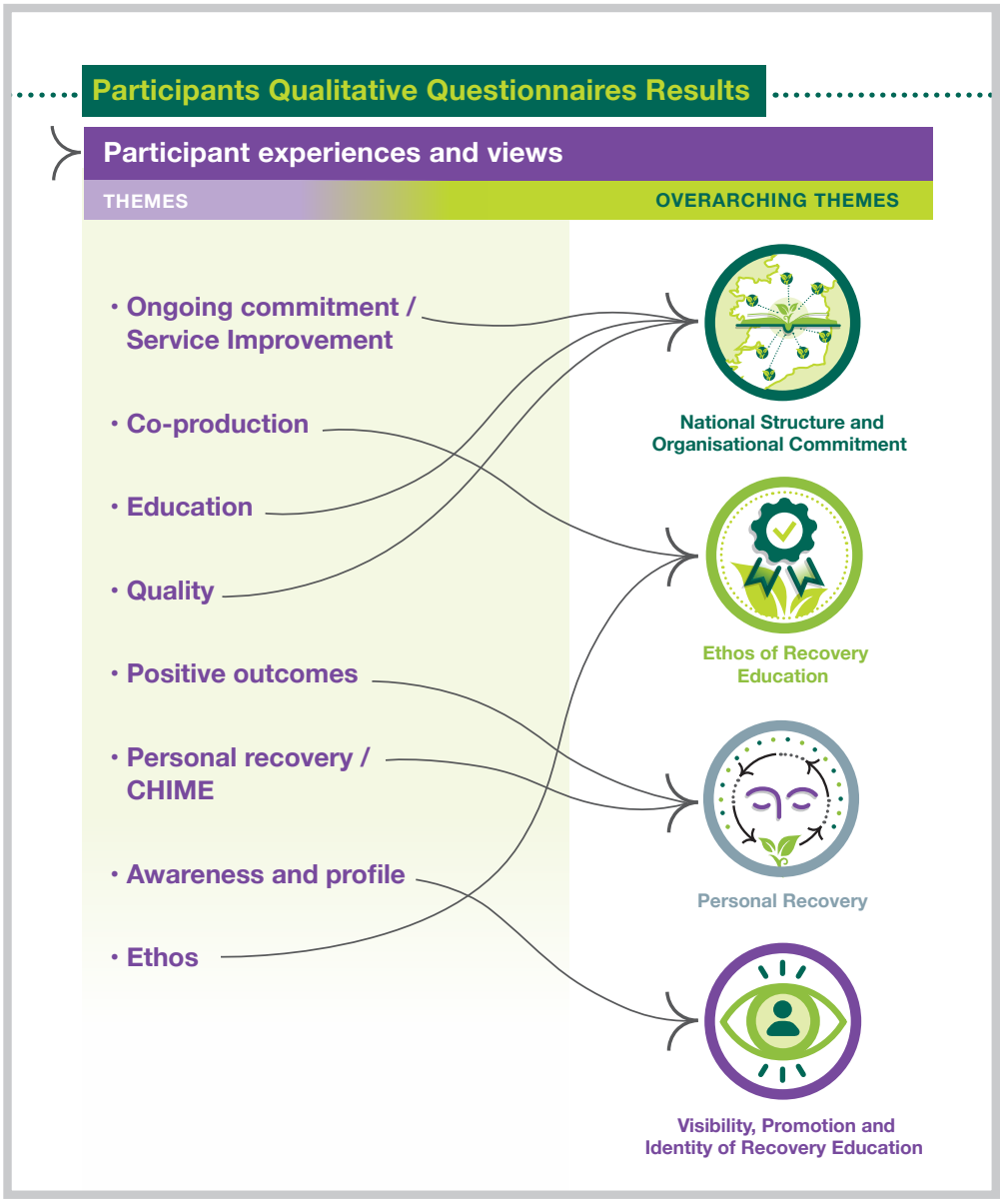
Amongst participants quotes was:

Overarching Themes

As alluded to earlier, findings across quantitative and qualitative data in this review complemented and reinforced each other. This stemmed from the quantitative participant survey right down through all the qualitative data. After further analysis of the combined findings outlined above reviewers identified common threads across all responses which coalesced into nine distinct but interrelated overarching themes.

Diagram A, below, shows the illustrative example of the process the authors utilised in refining all of the review themes into nine broader themes.
(A full illustration of this process is provided in the Appendix on page 72.)

DIAGRAM 1



The final Overarching Themes were:

National Structure and Organisational Commitment

Personal Recovery

Developing an Evidence Base and Clarity around Current Data Collection Processes in MHER

Internal and External Communication

Visibility, Promotion and Identity of Recovery Education

Strategic Leadership

Ethos of Recovery Education

Recruitment Processes

Strengthen Resources

Based on the data in this review, effectively addressing these key areas will be essential to support the future development and sustainability of recovery education in Mental Health Services in Ireland. A number of recommended actions have been identified through this review based on the nine overarching themes and are outlined following the discussion.

Discussion

This review set out to identify good examples of recovery education service provision in line with existing HSE guidance documentation and Service Level Agreement with the NGO partner Mental Health Ireland, the best structures and processes needed to ensure that recovery education is embedded within the HSE Mental Health Services and to inform the Office for Mental Health Engagement & Recovery recommendations to support the co-produced National Recovery Education Strategy in Mental Health Services. The review found nine overarching themes, outlined above, which may inform the future strategic direction in recovery education service provision in Ireland. The implications of these findings for the future of recovery education service provision in HSE Mental Health Services are discussed below.

Based on the findings, existing recovery education in Mental Health Services across the current structures is supporting people in their personal recovery journey. It is worth noting that the fundamental aim of recovery education is to enhance people's mental wellbeing through education, lived experience and co-production (Jones et al. 2024 p. 936). It also serves to break down mental health stigma in the community and within Mental Health Services and breaks down barriers and power imbalances between people with lived experience, service providers and family members/supporters (Hopkins et al. 2023). This review has heard from numerous participant and stakeholder accounts echoing the literature which is testament to the work that has happened in recovery education since its inception here in Ireland and for the future. Similarly, there are consistent findings in this review that support the literature around positive outcomes for participants of recovery education and participants experiencing the ethos of Recovery Colleges and Recovery Education Services. For instance, welcoming environment, language of hope, aspirations and empowerment Perkins et al. (2012), opportunities, increased self-awareness, increased self-confidence and worth (Thompson et al. 2021). Furthermore, the presence of co-production and adult education principles throughout current recovery education services is to be welcomed given Toney et al. (2019) assertion that they are non-modifiable components and essential for recovery education fidelity. Indeed, the remaining three non-modifiable components of valuing equality, tailored to the student and social connectedness were highly represented across our findings.

The reviewers identified a wide range of positive practices and processes across the country where organisational commitment was clearly demonstrated. This included the provision of resources, line management and governance structures as well as the Recovery Education Service being integral to service provision and where all stakeholders had an understanding of recovery education. Additionally, organisational commitment was clearly identified through examples of the Recovery Education Team attending and presenting at management team meetings, having an advisory and operational group, having a budget to support activities for recovery education, feeling valued, where the Recovery Education Service was reporting its data to service managers, service providers seeing recovery education as a reliable signpost and it being an integral choice within Mental Health Services.

In tandem with Jones et al. (2024, p. 943) overview of the operationalisation of recovery colleges, the current review found 'commonalities and heterogeneity' in Recovery College/Recovery Education Services operational characteristics. They found that organisational contexts, positioning and interpretations of key terminology and resource availability influence the ways in which recovery colleges are operationalised and understood. This may be reflective of how Recovery Education Services were described as disjointed throughout the review process. While it does not resolve the sense

of a disjointed landscape of recovery education it does perhaps bring some solace to realise that Ireland is not much different than other jurisdictions in this aspect of recovery education. However, this does not translate to a case of accepting the status quo but rather a unifying reminder that the recovery education movement is on a similar path to our counterparts in the UK, Australia and beyond and that it must keep going in what it believes.

A very prominent point from multiple participants was that of the visibility, identity and promotion of recovery education services which was strongly conveyed across the data. The main thrust of which revolved around the lack of understanding, awareness and visibility of recovery education both amongst Mental Health Service staff and the wider community sector including Primary Care, Community and Voluntary Sector and the general public. This issue was previously highlighted by O'Brien et al, (2024) who recommended promotion and awareness raising about recovery education to staff and linked it to part of the process for embedding recovery education within the Mental Health Services.

One of the latent findings of this review was the commitment, passion and belief in personal recovery, recovery education and the potential for service improvement and a whole service approach to recovery. These exact words were not necessarily expressed in this way but in reviewing what participants did respond with these qualities and leanings are evident. While there was some critical opinions and views shared, they were shared with a belief of a brighter future for Mental Health Services and with a belief and even an acceptance that this would materialise. One of the key underpinnings found in the data to facilitate next stage of transformation of Mental Health Services and recovery education is strong strategic leadership. As Hopkins et al, (2023) describes, recovery education does not function as effectively when it is seen as an add-on or side offering but must integrate with clinical services. Some of the terminology used by both literature and participants in this review was so similar at times it seemed as if participants had read up on the literature prior to participating in this review. What this tells us is that the findings here strongly align with the literature and that the voices of stakeholders need to be not only heard but listened to in any strategic directions that recovery education may take in the coming months and years ahead.

According to Hopkins et al, (2018) key findings from the implementation of Melbourne's Discovery College concur with international published evidence indicating factors for the effective implementation of recovery education. Among these is leadership engagement which needs to acknowledge the grassroots of the basis of Recovery Colleges but also effect a top-down input to achieve cultural change. Other key factors include having recovery champions in place to convey the message of recovery, engage in communication processes and help staff understand the recovery model. Recovery coordinators can play a crucial role in this as can all stakeholders from service providers, family members/carers, people with lived experience, community groups and members, volunteers and anyone who has an interest in recovery and seeing mental health challenges in a recovery-oriented way. In another example of the findings here supporting the literature, Hopkins et al highlight clarity around governance and identifying where recovery education or Recovery College sits and the implication of this in addressing issues like funding, oversight, policy and strategic direction. All these issues were conveyed by participants as needing urgent addressing to improve and sustain recovery education in Ireland. Respondents were adamant and clear that it is of utmost importance to have Recovery Education Services embedded in the HSE to be able to effectively realise the full potential of recovery education. The last factor outlined was one of administration capacity and how inadequate admin support completely hampers recovery education staff to deliver recovery education initiatives. In a similar vein, O Brien et al (2024) outline the need for stronger communication and commitment around strategies, national support and co-ordination.

Recommended Actions

- A co-produced national strategy for recovery education in Mental Health Services that will outline clear priorities, objectives, actions, outputs, outcomes, resources, timelines and ongoing evaluation processes.

- Create a joint governance structure with Access and Integration MHER, RHAs and supporting partner (NGO) providing a clear mandate outlining leadership, accountability, consistency and overall responsibility for the strengthening, development and sustainability of Recovery Education Services across all regions.

- Develop a standardised approach to recovery education in Mental Health Services across the regions building on best practice and current and emerging evidence.

- To ensure efficacy and consistency training in co-production, trauma – informed, managing boundaries, facilitation skills and using personal narrative should be standardised as part of the induction process for recovery education staff.

- A national shared drive and central repository should be established where co-produced materials, programmes, modules, presentations and resources can be stored and made available to Recovery Education Services across the regions. Oversight should be provided by a National Steering Group.

- Co-produce a communication and promotional plan for both internal and external stakeholders that would address understanding the role and purpose of recovery education in Mental Health Services, visibility, promotion of services, consistency of brand, messaging and communication pathways.

- A clear research and evaluation plan needs to be co-produced to validate the credibility and value of Recovery Education Services.

- A sustainable multi annual funding stream needs to be identified to protect current recovery education structures and expand services in response to a population-based approach.

- Revise all current recovery education guidance, resource and toolkits to align with the findings outlined in this review.

- Engage with the HSE HR and employment partners to review and address issues in relation to pay scales, progression, job specifications, equity and parity of role.

Conclusion

To lead and manage the evolution and implementation of recovery education in Mental Health Services MHER need to have devolved designated authority for accountability, governance and leadership. Successful and sustainable recovery education in Mental Health Services in Ireland are a very real possibility to aspire to. However, even in areas that have good practice and structures, there are inconsistencies. To achieve a quality assured, effective and efficient recovery education in Mental Health Services the reviewers identified the need to return to mapping out the national structures and reviewing where each element of the service has a role and responsibility in making this a reality.

Currently, from a national perspective, there is the office for MHER. Through our findings, the areas that need to be clearly outlined are, the role MHER play in resourcing, visibility, the provision of guidance documents, and a recovery education strategy with an implementation plan with clear actions, timelines, lead responsibilities, budgets and governance structure to support. From the findings, the key areas that came up were overarching governance and accountability, clarification of roles from national to regional to local and to the NGO partnership with Mental Health Ireland. The reviewers would emphasise the importance of the recommended actions being considered in the evolution of Recovery Education Services in Ireland.

If you would like a copy of the questionnaire or interview questions used in this review, please contact MHER by email at:

mhengage@hse.ie

With subject line: **Recovery Education review resource request.**

Appendix

A full illustration of the process of identifying the Overarching Themes.

Participants Qualitative Questionnaires Results

Participant experiences and views

THEMES	OVERARCHING THEMES
• Ongoing commitment / Service Improvement	National Structure and Organisational Commitment
• Co-production	
• Education	
• Quality	
• Positive outcomes	Ethos of Recovery Education
• Personal recovery / CHIME	Personal Recovery
• Awareness and profile	
• Ethos	Visibility, Promotion and Identity of Recovery Education

One-to-One Interviews

Experience of recovery education

THEMES (Topic 1) — OVERARCHING THEMES

- Commitment
- Leadership
- Cultural change
- Co-production
- CHIME
- Stigma reduction
- Personal narrative training
- Lack of consistency

National Structure and Organisational Commitment

Ethos of Recovery Education

Personal Recovery

Strategic Leadership

Purpose and who?

THEMES (Topic 2) — OVERARCHING THEMES

- For everyone
- Co-production
- Positive outcomes

Ethos of Recovery Education

Personal Recovery

Challenges

THEMES (Topic 2) | **OVERARCHING THEMES**

- Lack of national and regional leadership and structure
- Organisational culture
- Lack of visibility
- Ownership of recovery education
- Contracts
- Lack of policies
- Lack of sustained funding
- Lack of evidence to validate recovery education

National Structure and Organisational Commitment

Visibility, Promotion and Identity of Recovery Education

Recruitment Processes

Developing an Evidence Base and Clarity around Current Data Collection Processes in MHER

One-to-One Interviews

Evidence

THEMES (Topic 3) | OVERARCHING THEMES

- Lack of clarity on purpose of data collection
- Inconsistencies on data collection
- No national leadership on research or evaluation in recovery education
- Set national standards for quality in programmes/ modules co-production
- Avoid duplication of modules
- Innovate data collection to validate recovery education

Strategic Leadership

Developing an Evidence Base and Clarity around Current Data Collection Processes in MHER

Strengthen Resources

One-to-One Interviews

Operational Structures

THEMES (Topic 4) | OVERARCHING THEMES

- HSE national leadership
- National plan for rolling out recovery education across the country
- Lack of clarity on where it sits within overall Mental Health Services

Strategic Leadership

Visibility, Promotion and Identity of Recovery Education

Future of Recovery Education Services

THEMES (Topic 5) | OVERARCHING THEMES

- National structure
- Visibility
- Embedded in HSE
- Clarity of ownership

Strategic Leadership

Visibility, Promotion and Identity of Recovery Education

Qualitative Surveys

Experience of recovery education

THEMES (Topic 1)

- Relevant recovery education in Mental Health Services
- CHIME
- Co-production
- Personal recovery
- Multi-skill set

OVERARCHING THEMES

Visibility, Promotion and Identity of Recovery Education

Recruitment Processes

Personal Recovery

Who and benefits

THEMES (Topic 2)

- Addresses power imbalance
- Reduces stigma
- Personal recovery
- CHIME
- Co-production
- Adult education
- Recovery education for all

OVERARCHING THEMES

National Structure and Organisational Commitment

Personal Recovery

Ethos of Recovery Education

Qualitative Surveys

Evidence

THEMES (Topic 3) | OVERARCHING THEMES

- Variety of data gathering
- Uncertainty around type and use of data

Clarity around Current Data Collection Processes in MHER

- Mixed methods of reseach
- Measure impact outwards

Developing an Evidence Base

Qualitative Surveys

Sustainability

THEMES (Topic 1) | **OVERARCHING THEMES**

- Improved work conditions
- Organisational commitment
- Quality control
- Strategic direction
- Work conditions
- Work practice
- Recruitment
- Job spec
- Better understanding of roles in HSE and existing recovery education staff
- HSE responsible
- Responsibility of all co-production

Recruitment Processes

Strategic Leadership

Visibility, Promotion and Identity of Recovery Education

Ethos of Recovery Education

Qualitative Surveys

Future of Recovery Education Services

THEMES (Topic 5)	OVERARCHING THEMES

- Credible identity
- Core funding
- Co-production is key

Visibility, Promotion and Identity of Recovery Education

Strengthen Resources

Ethos of Recovery Education

Experience of recovery education

THEMES (Topic 1) | OVERARCHING THEMES

- Recovery journey
- Work opportunities
- Organisational change
- Adult learning
- CHIME
- Recovery education for all
- Service improvement
- Fostering recovery
- Ethos

Personal Recovery

Ethos of Recovery Education

Recruitment Processes

National Structure and Organisational Commitment

Improving recovery education

THEMES	OVERARCHING THEMES

- Resources, staff and work conditions
- Recovery education needs to be better understood / identity is essential
- Organisational commitment needs to be prioritised

Strengthen Resources

Visibility, Promotion and Identity of Recovery Education

National Structure and Organisational Commitment

Focus Groups

Sustainability

THEMES

OVERARCHING THEMES

- Leadership
- Strategic direction
- Recovery education identity and promotion
- Career structures
- Embedded in HSE

Strategic Leadership

Visibility, Promotion and Identity of Recovery Education

Recruitment Processes

Focus Groups

Responsibility

THEMES | OVERARCHING THEMES

- HSE Mental Health Services
- Department of health
- MOU lacks clarity

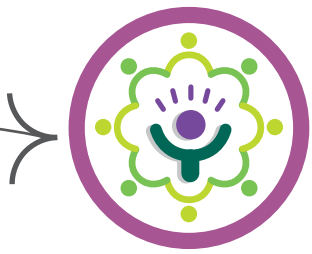
Strategic Leadership

Visibility, Promotion and Identity of Recovery Education

Role of MHER

THEMES | OVERARCHING THEMES

- Coordinating information and guidance



Strategic Leadership

Focus Groups

Evidence

THEMES | OVERARCHING THEMES

- Prioritise research and evidence base

Developing an Evidence Base

- Establish clarity around current data gathering processes

Clarity around Current Data Collection Processes in MHER

Future

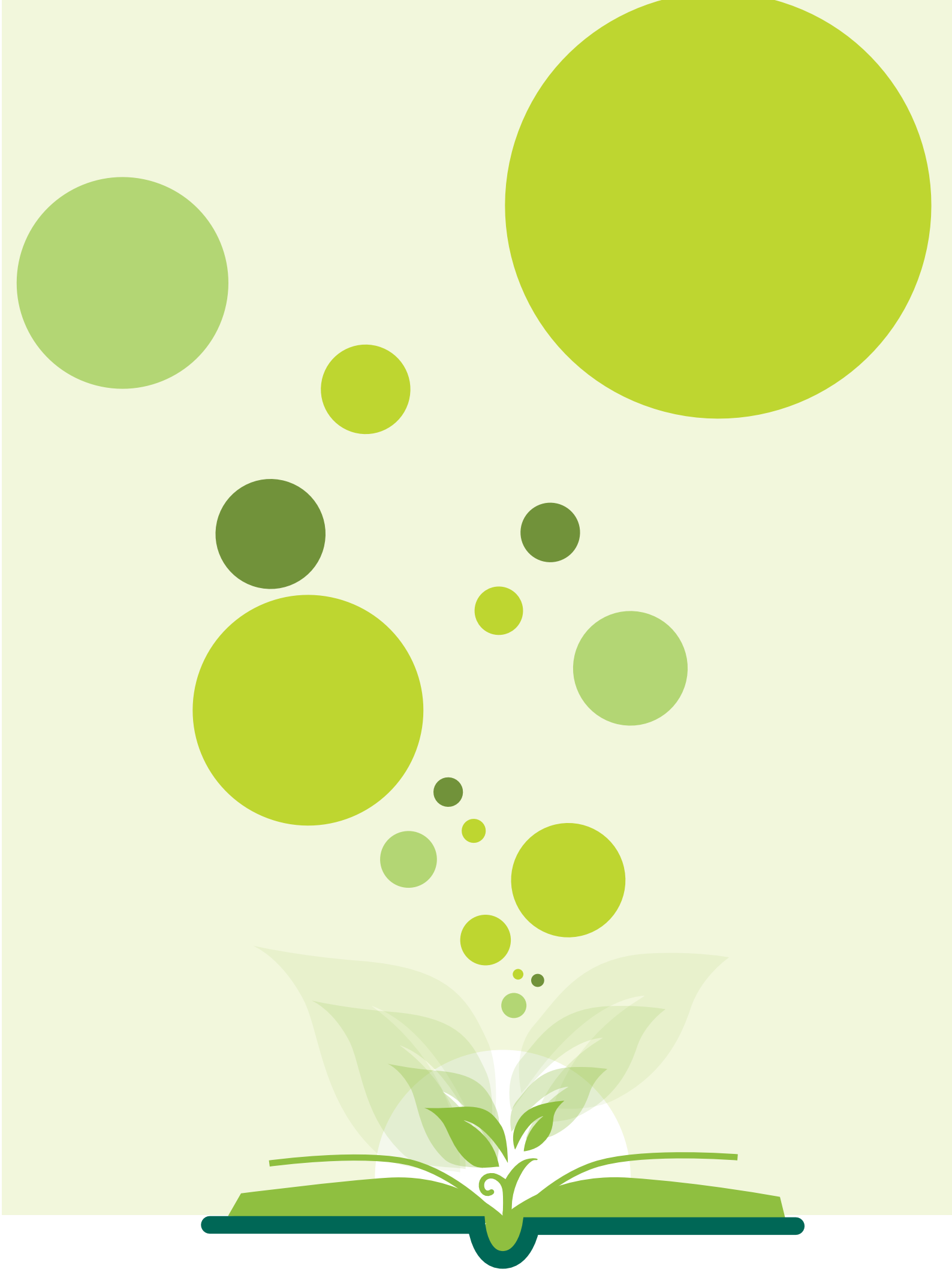
THEMES | OVERARCHING THEMES

- Structure and identity for recovery education

Visibility, Promotion and Identity of Recovery Education

- Availability to all

Ethos of Recovery Education



Bibliography

Allan V. Horwitz, A., V. (2012). *An Overview of Sociological Perspectives on the Definitions, Causes, and Responses to Mental Health and Illness*, Published online by Cambridge University Press. (Accessed 10.7.24). >Available here

Allard, J., Pollard, A., Laugharne, R., Coates, J., Wildfire-Roberts, J., Millward, M., & Shankar, R. (2024). *Evaluating the impact of a UK recovery college on mental well-being: pre- and post-intervention study*. BJPsych Open, 10(3), e87. (Accessed 10.7.24) >Available here

Anthony, W. A. (1993). *Recovery from mental illness: The guiding vision of the mental health service system in the 1990s*. Psychosocial Rehabilitation Journal, 16(4), 11–23. >Available here

Berger, R. (2015). **Now I see it, now I don't: researcher's position and reflexivity in qualitative research.** Qualitative Research, 15(2), 219-234. >Available here

Braun V, Clarke V. *Using thematic analysis in psychology.* Qual Res Psychol. 2006;3(2):77-101.

Changing Directions, Changing Lives: The Mental Health Strategy for Canada, (2012). >Available here

Cook, J. A., Copeland, M. E., Jonikas, J. A., Hamilton, M. M., Razzano, L. A., Grey, D. D., Floyd, C. B., Hudson, W. B., Macfarlane, R. T., Carter, T. M., & Boyd, S. (2012). *Results of a randomized controlled trial of mental illness self-management using Wellness Recovery Action Planning*. Schizophrenia bulletin, 38(4), 881–891. >Available here

Cook, J. A., Steigman, P., Pickett, S., Diehl, S., Fox, A., Shipley, P., MacFarlane, R., Grey, D. D., & Burke-Miller, J. K. (2012). *Randomized controlled trial of peer-led recovery education using Building Recovery of Individual Dreams and Goals through Education and Support (BRIDGES)*. Schizophrenia research, 136(1-3), 36–42. >Available here

Crowther, A., Taylor, A., Toney, R., Meddings, S., Whale, T., Jennings, H., Slade, M. (2019). *The impact of Recovery Colleges on mental health staff, services and society.* Epidemiology and psychiatric sciences, 28(5), 481-488. >Available here

Department of Health and Children, (2006) *A Vision for Change* >Available here

Department of Health (2019) *Slaintecare Action Plan 2019* >Available here

Department of Health (2020) *Sharing the Vision: A Mental Health Policy for Everyone* (accessed 10.7.24) >Available here

Department of the Taoiseach, (2025) *Programme for Government 2025 - Securing Ireland's Future* (Accessed 10.2.25) >Available here

Durbin, A., Nisenbaum, R., Wang, R., Hwang, S. W., Kozloff, N., & Stergiopoulos, V. (2021)**.** *Recovery Education for Adults Transitioning From Homelessness: A Longitudinal Outcome Evaluation.* Frontiers in psychiatry, 12, 763396. (Accessed 10.7.24) >Available here

Eiroa-Orosa, F. J., & García-Mieres, H. (2019). *A Systematic Review and Meta-analysis of Recovery Educational Interventions for Mental Health Professionals.* Administration and policy in mental health, 46(6), 724–752. (Accessed 10.7.24) >Available here

Hayes, D., Camacho, E. M., Ronaldson, A., Stepanian, K., McPhilbin, M., Elliott, R. A., Repper, J., Bishop, S., Stergiopoulos, V., Brophy, L., Giles, K., Trickett, S., Lawrence, S., Winship, G., Meddings, S., Bakolis, I., Henderson, C., & Slade, M. (2024). *Evidence-based Recovery Colleges: developing a typology based on organisational characteristics, fidelity and funding.* Social psychiatry and psychiatric epidemiology, 59(5), 759–768. (Accessed 10.7.24) >Available here

Hayes, D., Henderson, C., Bakolis, I. et al. *Recovery Colleges Characterisation and Testing in England (RECOLLECT): rationale and protocol.* BMC Psychiatry 22, 627 (2022). (Accessed 10.7.24) >Available here

Hayes, D., Hunter-Brown, H., Camacho, E., McPhilbin, M., Elliott, R. A., Ronaldson, A., Bakolis, I., Repper, J., Meddings, S., Stergiopoulos, V., Brophy, L., Miyamoto, Y., Castelein, S., Klevan, T. G., Elton, D., Grant-Rowles, J., Kotera, Y., Henderson, C., Slade, M., & RECOLLECT International Research Consortium (2023). *Organisational and student characteristics, fidelity, funding models, and unit costs of recovery colleges in 28 countries: a cross-sectional survey.* The Lancet. Psychiatry, 10(10), 768–779. (Accessed 10.7.24) >Available here

Hopkins L, Saraf S, Foster A. (2023). *Establishing Recovery Colleges in mental healthcare services: A Royal Commission recommendation***.** Australian & New Zealand Journal of Psychiatry. 57(1):17-20. (Accessed 10.7.24) >Available here

Hopkins, L., Foster, A., Nikitin, L. (2018). *"The process of establishing Discovery College in Melbourne"***,** Mental Health and Social Inclusion, Vol. 22 No. 4, pp. 187-194. (Accessed 10.7.24) >Available here

Horgan A, Manning F, Donovan MO, Manning, F., Doody, R., Savage, E., Bradley, S., Dorrity, C., O'Sullivan, H., Goodwin, J., Greaney, S., Biering, P., Bjornsson, E., Bocking, J., Russell, S., MacGabhan, L., Griffin, M., Jan van der Vaart, K., Allon, j., Granerud, A., Hals, E., Pulli, J., Annaliina, V., Ellila, H., Lahti, M., Happell, B. (2020). *Expert by experience involvement in mental health nursing education: the co-production of standards between experts by experience and academics in mental health nursing.* J Psychiatry Mental Health Nursing. 27(5): 553-562. (Accessed 10.7.24) >Available here

HSE (2017) *National Framework for Recovery in Mental Health* (Accessed 10.7.24) >Available here

HSE (2024a) *National Implementation Plan - National Service Plan 2024 continues to move the HSE towards the goal of universal healthcare in line with the ambitions of the Government and of Sláintecare* (Accessed 10.7.24) >Available here

HSE (2018a). *CO-PRODUCTION IN PRACTICE GUIDANCE DOCUMENT 2018 – 2020, Supporting the Implementation of 'A National Framework for Recovery in Mental Health 2018-2020'* (Accessed 10.7.24) >Available here

HSE (2018b) *FAMILY RECOVERY GUIDANCE DOCUMENT 2018 - 2020 Supporting 'A National Framework for Recovery in Mental Health 2018-2020'* (Accessed 10.7.24) >Available here

HSE (2018c). *RECOVERY EDUCATION GUIDANCE DOCUMENT 2018 - 2020 Supporting 'A National Framework for Recovery in Mental Health 2018-2020***'** (Accessed 10.7.24) >Available here

HSE (2020a). *RESOURCES to Support the Development and Implementation of Recovery Education 2020-2025.* (Accessed 10.7.24) >Available here

HSE (2020b) *TOOLKIT to Support the Development and Implementation of Recovery Education 2020-2025,* (Accessed 10.7.24) >Available here

HSE (2023) *Strategic Plan 2023-2026,* Engaged in Recovery, Mental Health Engagement and Recovery Office, (Accessed 10.7.24) >Available here

HSE (2024b). *A National Framework for Recovery in Mental Health 2024–2028* (Accessed 10.7.24) >Available here

HSE (2024c). *Ethical Approval for Research in the HSE & its funded organisations* (Accessed 10.7.24) >Available here

HSE (2024d). *Advancing Recovery in Ireland (ARI), What was ARI?* (Accessed 10.7.24) >Available here

ImRoc (2024) *Portfolio, Briefing Paper* (Accessed 10.7.24) >Available here

Jones, K., Crawford, G., Mahboub, L., & Jancey, J. (2024). *The operationalisation of recovery colleges: A scoping review.* Health promotion journal of Australia: official journal of Australian Association of Health Promotion Professionals, 35(4), 936–946. (Accessed 10.1.24) >Available here

Just Economics Research (2020) *Recovery Education in Ireland A review of the existing evidence and a proposal for future evaluation,* Just Economics Ltd.

Kenny, B., Kavanagh, E., Mc Sherry, H., Brady, G., Kelly, J., Mac Gabhann, L., Griffin, M., Farrelly, M., Kelly, N., Ross, P., Barron, R., Watter, R., Keating, S. (2020) *Dublin North, North East Recovery College: Informing and transforming communities, shaping the way forward for mental health recovery.* Dublin City University ISBN number: 978-1-911669-09-8 >Available here

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

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). *Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis.* The British journal of psychiatry : the journal of mental science, 199(6), 445–452. >Available here

Lin E, Harris H, Gruszecki S., Costa-Dookhan., K., Rodak, T., Sockalingam, S., Soklaridis, S. (2022). *Developing an evaluation framework for assessing the impact of recovery colleges: protocol for a participatory stakeholder engagement process and cocreated scoping review.* BMJ Open, 12:e055289. doi:10.1136/ bmjopen-2021-055289 (Accessed 10.7.24) >Available here

Lin, E., Harris, H., Black, G., Bellissimo, G., Di Giandomenico, A., Rodak, T., Costa-Dookhan, K. A., Shier, R., Rovet, J., Gruszecki, S., & Soklaridis, S. (2023). *Evaluating recovery colleges: a co-created scoping review*. Journal of Mental Health (Abingdon, England), 32(4), 813–834. (Accessed 10.7.24) >Available here

Lin, E., Harris, H., Black, G., Bellissimo, G., Di Giandomenico, A., Rodak, T., … Soklaridis, S. (2022). *Evaluating recovery colleges: a co-created scoping review.* Journal of Mental Health, 32(4), 813–834. (Accessed 10.7.24) >Available here

Mental Health Act, (2001) Irish Statute Book, (Accessed 10.7.24) >Available here

No Health Without Mental Health: a cross-government outcomes strategy, (2011). (Accessed 10.7.24) >Available here

O'Brien A, Murphy L, Hunt A, Dwyer D, Hunter A. *A co-created multimethod evaluation of recovery education in Ireland.* Health Expect. 2024; 27:e13937 >Available here

Perkins, R., Repper, J., Rinaldi, M., Brown, H. (2012). *Recovery Colleges - Implementing Recovery through Organisational Change* >Available here

Rogers, E. S., Chamberlin, J., Ellison, M. L., & Crean, T. (1997). *A consumer-constructed scale to measure empowerment among users of mental health services.* Psychiatric Services, 48(8), 1042–1047 >Available here

Slade M. (2010) *Mental illness and well-being: the central importance of positive psychology and recovery approaches.* BMC Health Serv Res 10:1–14. >Available here

Slade, M. (2009). *Personal Recovery and Mental Illness: A Guide for Mental Health Professionals.* Cambridge University Press.

Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., Perkins, R., Shepherd, G., Tse, S., & Whitley, R. (2014). *Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems.* World psychiatry : official journal of the World Psychiatric Association (WPA), 13(1), 12–20. >Available here

Theriault, Joanie & Lord, Marie-Michèle & Briand, Catherine & Piat, Myra & Meddings, Sara. (2020). *Recovery Colleges After a Decade of Research: A Literature Review.* Psychiatric services (Washington, D.C.). 71. Accessed 10.7.24) >Available here

Thompson, H., Simonds, L., Barr, S., & Meddings, S. (2021). *Recovery colleges: long-term impact and mechanisms of change.* Mental Health and Social Inclusion. Accessed 10.7.24) >Available here

Toney R, Elton D, Munday E, et al. (2018). *Mechanisms of action and outcomes for students in recovery colleges*. Psychiatr Serv. 69(12):1222-1229. >Available here

Toney, R., Knight, J., Hamill, K., Taylor, A., Henderson, C., Crowther, A., Meddings, S., Barbic, S., Jennings, H., Pollock, K., Bates, P., Repper, J., & Slade, M. (2019). *Development and Evaluation of a Recovery College Fidelity Measure.* Canadian journal of psychiatry. Revue canadienne de psychiatrie, 64(6), 405–414. >Available here

van Wezel, M.M.C., Muusse, C., van de Mheen, D. et al. *What do we not know (yet) about recovery colleges? A study protocol on their (cost-)effectiveness, mechanisms of action, fidelity and positioning.* BMC Psychiatry 23, 816 (2023). >Available here

Whish, R., Huckle, C., & Mason, O. (2022). *What is the impact of recovery colleges on students? A thematic synthesis of qualitative evidence.* The Journal of Mental Health Training, Education and Practice. ahead-of-print. 10.1108/JMHTEP-11-2021-0130, Accessed 10.7.24) >Available here

WHO (2013). *Mental Health Action Plan 2013 – 2020, (2013).* Accessed 10.7.24) >Available here

Williams, V.C., Deane, F.P., Oades, L.G., Crowe, T.P., Ciarrochi, J. and Andresen, R. (2016). *Enhancing recovery orientation within mental health services: expanding the utility of values*, The Journal of Mental Health Training, Education and Practice, Vol. 11 No. 1, pp. 23-32. >Available here

Wilson C., King M., Russell J. (2019) *A mixed-methods evaluation of a Recovery College in South East Essex for people with mental health difficulties.* Health Soc Care Community, 27(5): 1353-1362. >Available here

World Health Organization, (2022). *World mental health report: transforming mental health for all.*

Yoeli H, Ryan A, Hensby C, Habermehl F, Burton S, Sin J. (2022). *Recovery in mind: a recovery college's journey through the Covid-19 pandemic.* Health Expect. 25(6):3274-3286. >Available here

ZabelE,DoneganG,Lawrence K,French P. (2015). *Exploring the impact of a recovery academy: a qualitative study of recovery college experiences*. J Ment Health Train Educ Pract. 11(3):162-171. >Available here

A comprehensive review of the existing structures and processes in the delivery of recovery education within the HSE Mental Health Services.

HSE Access & Integration – Office of Mental Health Engagement and Recovery

@mher_Ireland @HSELive

www.hse.ie/eng/servicecs/list/4/mental-health-services/mental-health-engagement-and-recovery