justified on cost-effectiveness alone, with many more required for full national coverage[5].

Each region of Australia needs a cluster of headspace entry-level portals seamlessly linked to transdiagnostic specialized care integrating mental and physical health with alcohol and other drugs expertise, vocational interventions and online/digital health platforms. Assertive and intensive home-based care, and clinicians with expertise in complex syndromes (such as borderline, eating, mood and psychotic disorders) are missing elements, and interface with hospital-based services is therefore needed. Strong national oversight to assure integrative commissioning, stronger financial models, additional funding streams, longer tenure and greater depth of expertise will strengthen the capacity of the model.

The youth mental health paradigm is in its infancy and will be driven by a dynamic blend of grassroots and professional leadership[8]. Early adopters, inspiring leaders, philanthropic visionaries and patrons have emerged in progressive regions of the world, notably Ireland, Canada, Denmark, Israel, the Netherlands, France, Singapore, and parts of England and California[9]. Child and adolescent psychiatry, still a seriously undersized speciality, has begun to recognize the need and opportunity for a paradigm shift, which it has labelled "transitional psychiatry". Momentum within and beyond the mental health field is building and could be decisive in paving the way for a wider revolution in mental health care.

Patrick McGorry[1-3], Jason Trethowan[3], Debra Rickwood[3]
[1]Orygen, The National Centre of Excellence in Youth Mental Health, Parkville, Australia; [2]Centre for Youth Mental Health, University of Melbourne, Parkville, Australia; [3]headspace, the National Youth Mental Health Foundation, Melbourne, Australia

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Recovery colleges as a mental health innovation

There is a consensus among the mental health community that recovery from mental illness involves much more than symptom remission. Indeed, people with mental illness often define recovery in terms of living a meaningful, autonomous and empowered life in the community[1]. Yet they continue to experience numerous inequalities, including high rates of unemployment, low rates of educational attainment, considerable public stigma and social exclusion.

Recovery colleges are a new initiative aimed at people with mental illness to support their recovery and address these inequalities. The first recovery colleges emerged in the US in the 1990s, informing a model that has been adapted and implemented across the world in the last decade[1]. In 2009, the first recovery college opened in London, and there are now more than 70 in the UK[2]. Recovery colleges now exist in over 20 countries, including Hong Kong, Italy, Sri Lanka, Israel, Japan and the Netherlands. Moreover, a recovery college international community of practice has been established to promote research, knowledge exchange and understanding.

Some descriptive research has examined the defining characteristics, core values and central features of recovery colleges. These are mostly single-site case studies[3,4], which have been compared for shared themes in two recent systematic literature reviews[5,6]. These studies indicate several common core characteristics across recovery colleges.

First, recovery colleges tend to be based on the theory and practice of adult education, rather than clinical or therapeutic models[3]. As such, they possess many of the core characteristics of an adult education college: registration, enrollment, term curricula, full-time staff, sessional teachers and a yearly cycle of classes. Attendees are students (not patients, clients or service users), and they strive to be serious places of learning[2]. As such, some colleges are physically located in mainstream adult education institutes (e.g., Mayo Recovery College, Ireland) or higher education settings (e.g., Boston University Recovery Education Program).

Second, they offer a range of educational courses that individual students can tailor to their own specific circumstances. These courses often focus on equipping students with new skills that can foster various aspects of their (broadly defined) recovery[5,6]. This can include courses on health related factors such as illness management, self-care and physical health; as well as courses on life skills, employment and information technology[2,4,7].

Third, recovery colleges are characterized by the meaningful involvement of people in recovery (peers) in all aspects of college life[3-5]. Peers are often employed as course teachers, either alone or in conjunction with other experts. This is known as co-delivery. Peers are also frequently involved in college governance and management, with strong input into decisions about curriculum, structure, staffing and overall philosophy. This collaboration between professionals and peers is known as co-production. The emphasis on co-delivery and co-production makes recovery colleges distinct from traditional educational practice.

Recovery colleges receive operating funds from a variety of organizations, including official health services, non-profit and corporate donations; as well as government employment and education departments[2,7]. The existing descriptive literature

indicates that the physical location of recovery colleges differs considerably[2,6]. Some are in the community (e.g., Calgary Recovery College, Canada), while others are within hospitals and mental health services (e.g., Butabika Recovery College, Uganda). New models are also emerging, such as online recovery colleges (e.g., https://lms.recoverycollegeonline.co.uk/). Given this variation, research comparing different funding and service delivery models is needed.

Current evidence indicates that recovery colleges are popular with students, and that college experience can be beneficial to recovery[6,7]. Furthermore, colleges can engage people who find existing services unappealing, and are associated with self-reported improvements in several domains, including self-esteem, self-understanding and self-confidence. Futhermore, students have reported a positive impact on occupational, social and service use outcomes.

Indeed, recovery colleges have the potential to equip students with new skills that can help their entry into the workforce[5,6], but there is little quantitative research examining specific impact on employment outcomes. Interestingly, a recent empirical study indicates that colleges may have beneficial impacts beyond the student, by positively affecting the attitudes of mental health staff, reducing stigma within health and social service systems, and increasing inclusiveness in wider society[9].

Research and evaluation examining recovery colleges is expanding, with ongoing studies in Canada, England and elsewhere. That said, most existing research has uncontrolled, single-case or retrospective designs. There is a lack of rigorous quantitative research and there has not been any randomized trial. Nonetheless, this situation is rapidly changing. A recent rigorous study used a controlled before-and-after design to analyze mental health service use in a large sample of recovery college students, finding that students had lower rates of service utilization after attending a college[8].

Similarly, a 39-college UK study developed and psychometrically validated recovery college implementation checklists and a fidelity scale (available at researchintorecovery.com/recollect) to assess modifiable and non-modifiable components[5]. This study confirmed that an educational approach and the use of co-production are foundational to recovery colleges. Importantly, most research has occurred in high-income anglophone countries such as the UK, US, Canada and Australia, indicating a need for further research elsewhere.

In summary, recovery colleges are a tangible manifestation of the international push to make the mental health system more recovery-oriented[1]. They are a pioneering intervention that enact much of the theory and evidence surrounding recovery. First, they can help students address functional and educational deficits that contribute to high rates of social exclusion. Second, they can equip students with self-care techniques, encouraging them to successfully manage their illness and take control of their life[2]. Third, they are based on an effective partnership between experts by experience (peers) and experts by training (clinicians)[3]. Hence, recovery colleges have the potential to foster individual student recovery, as well as catalyze wider service change and reduce societal stigma[6,9].

In conclusion, recovery colleges offer something very different from current pharmacological and psychological interventions. They have enthusiastic proponents, but rigorous evidence about their impact on outcomes is missing. In particular, randomized controlled trials are needed which evaluate their impact on social and functional outcomes, as much as clinical and service use outcomes.

Rob Whitley[1], Geoff Shepherd[2,3], Mike Slade[4]
[1]Douglas Mental Health University Institute, Department of Psychiatry, McGill University, Montreal, Canada; [2]Implementing Recovery through Organisational Change (ImROC), Nottinghamshire Healthcare NHS Foundation Trust, Nottingham, UK; [3]Department of Health Services Research, Institute of Psychiatry, Psychology and Neuroscience, King's College London, London, UK; [4]School of Health Sciences, Institute of Mental Health, University of Nottingham, Nottingham, UK.

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Mental Health First Aid training: lessons learned from the global spread of a community education program

Many health education interventions achieve limited dissemination, even when there is supporting evidence for their efficacy[1]. We think there are lessons to be learned for those aiming to disseminate such interventions from those rare examples where the dissemination has been successful. Here we describe the factors that appear to underlie the success of one such program: Mental Health First Aid (MHFA) training.

The MHFA training program conducts courses which teach members of the public how to provide mental health first aid, which has been defined as "the help offered to a person developing a mental health problem, experiencing a worsening of an existing mental health problem or in a mental health crisis; the first aid is given until appropriate professional help is received or until the crisis resolves"[2]. Participants are trained to: approach, assess and assist with any crisis; listen and communicate non-judgmentally; give support and information; encourage appropriate professional help; encourage other supports.