

Psychiatrist's views on Recovery Colleges

Abstract

Purpose: The purpose of this paper is to provide insight into the views and attitudes that psychiatrists have about Recovery Colleges (RCs).

Design/Methodology/approach: Semi-structured interviews were conducted with 10 psychiatrists from the Norfolk and Suffolk Foundation Trust (NSFT).

Findings: Psychiatrists had a strong concept of the RC model, and were broadly positive about it, recognising many benefits. Various challenges were also acknowledged including how the RC model interacts with the medical model.

Originality/Value: This is the first known study to explore solely psychiatrist's views of RCs, a group who are likely to be particularly influential within services. The sample was relatively unexposed to RCs, enabling insight into how the RC is perceived by those outside of its functioning as well as the state of wider organisational support, which is important for the success of RCs.

Keywords: Recovery College, recovery, psychiatrist, mental health, attitudes

Introduction

Recovery

Mental health services are increasingly committed to being 'recovery focussed'. This means implementing approaches that foster hope, give people back control over their lives, help them to develop valued roles and relationships as well as finding meaning and purpose (Meddings *et al.*, 2015a). Services are required to move beyond a merely symptom reduction approach to a broader recovery approach (Meddings *et al.*, 2015a, Perkins and Slade 2012), which is now required by mental health policy (Department of Health 2011). IMROC (Implementing recovery through organisational change) is an initiative delivered by the Department of Health that provides guidance and structure for organisations to become recovery-focussed (Perkins *et al.*, 2017, Shepherd *et al.*, 2010) and state that major organisational changes are required for organisations to achieve this (Perkins *et al.*, 2012).

Shepherd *et al* (2010) identified 10 organisational challenges required to become recovery-focussed, including shifting from reducing symptoms to rebuilding lives, a shift from professionals 'on top' to 'on tap' and recognition of the equal value of lived experience and professional expertise. It can be argued that Recovery Colleges (RCs) embody all these values and are therefore a driving force behind truly recovery-orientated services (Perkins *et al.*, 2012).

What are RCs?

Recovery education centres were developed in USA and subsequently emerged in the UK first in South West London in 2009 (Hans 2013) and then Nottingham in 2011 (Perkins *et al.*, 2012, McGregor *et al.*, 2014). They have grown rapidly due to popular demand (Perkins and Repper 2017, Perkins *et al.*, 2012) and there are currently 40 RCs in the world, mainly in England, but also in Scotland, Ireland, Italy, Australia, Japan and Singapore (Perkins and Repper 2017, Meddings *et al.*, 2015b).

RCs offer an educational approach compared to the traditional therapeutic approach (Meddings *et al.*, 2015a, Perkins *et al.*, 2012, Zucchelli and Skinner 2013, Meddings *et al.*, 2015b, McGregor *et al.*, 2014), whereby service users become students and select different courses to attend, which are all mental health and recovery related (Meddings *et al.*, 2014a, Meddings *et al.*, 2015a, Zucchelli and Skinner 2013). Courses should all have the principles of hope, control and opportunity at heart (Zucchelli and Skinner 2013). RCs provide a strengths-based approach (McGregor *et al.*, 2014), enabling individuals to develop skills, achieve personal goals and lead in their own recovery in partnership with professionals (Meddings *et al.*, 2014b, Perkins *et al.*, 2012, McGregor *et al.*, 2014). They enable individuals to take control of their recovery and improve their wellbeing (Meddings *et al.*, 2014a, Meddings *et al.*, 2014b, McGregor *et al.*, 2014), which can be empowering (Meddings *et al.*, 2014b, Zucchelli and Skinner 2013). They are about helping people understand and manage their own challenges and gain confidence and self-belief by recognising their abilities and potential (Perkins *et al.*, 2012, Rinaldi and Suleman 2012).

Perkins *et al.* (2012) set out eight defining features of RCs including; co-production (between staff and service users), the presence of a physical base, an emphasis on college principles (e.g. selecting courses), having personal tutors and not being a substitute for mainstream colleges. RCs are for everyone including staff, family, carers and service users (Meddings *et al.*, 2014a, Perkins *et al.*, 2012, Zucchelli and Skinner 2013, Meddings *et al.*, 2015b). There should be no selection or referral of people to RCs based on professional judgement (Perkins and Repper 2017). They are not a substitute for traditional assessment and treatment (Perkins *et al.*, 2012) but are a place where both lived and professional experience can be brought together (Meddings *et al.*, 2014a, Meddings *et al.*, 2014b, Perkins *et al.*, 2012, Meddings *et al.*, 2015b).

RCs in the UK are unique in their design by emphasising co-production, co-learning, the expertise of lived experience (Perkins and Repper 2017, Zucchelli and Skinner 2013, Meddings *et al.*, 2015b, McGregor *et al.*, 2014). Differing from the traditional college model the content of RC courses is student-led, thus RCs are also creating something completely new (McGregor *et al.*, 2014).

RCs place great value on lived experience, viewing people not as patients but as experts (Perkins *et al.*, 2012, Zucchelli and Skinner 2013), they are founded on co-production and co-delivery – staff and service users working alongside each other (Perkins and Repper 2017, Meddings *et al.*, 2015a, Perkins *et al.*, 2012, Zucchelli and Skinner 2013, Hans 2013, McGregor *et al.*, 2014). In addition, it has been argued that RCs can help overcome stigma and social isolation, bringing together people with a range of mental health and related challenges and providing a service to the broader community (Perkins and Repper 2017).

Evidence base

The evidence base for RCs is limited with most evidence coming from audits, evaluations, case studies and self-reported measures (Dunn *et al.*, 2016, Perkins *et al.*, 2012, Meddings *et al.*, 2015b). Results so far suggest RCs can be efficient and significantly contribute to recovery and wellbeing (Meddings *et al.*, 2015a). There are numerous reports of positive feedback with RCs being generally very well received and popular (Meddings *et al.*, 2015a,

Meddings *et al.*, 2014b, Zucchelli and Skinner 2013, Meddings *et al.*, 2015b, Perkins *et al.*, 2017, Zabel *et al.*, 2016, Rinaldi and Suleman 2012), including by NHS staff (Perkins *et al.*, 2017). Meddings *et al.* (2015a) reported benefits for students included gaining confidence, increasing knowledge or skills and meeting other people.

Views on RCs

There are a small number of studies that have researched how RCs have been received by those who have participated in them, including services users, carers and staff. Generally, studies report people responding positively towards RCs (Meddings *et al.* (2014b), Perkins *et al.* 2017, Skipper and Page 2015, Zabel *et al.* 2016), citing numerous benefits including the valuing of both lived and professional experience, helping to lift mood, build confidence, inspire hope and optimism and improve self-esteem. Additionally, it has been reported that RCs can positively impact staff attitudes and behaviours (Zabel *et al.* 2016) as well as reduce staff burnout (Perkins *et al.* 2017). More specifically, Skipper and Page (2015) reported that staff whom become involved in RCs have reported better job satisfaction and sense of wellbeing. Staff involvement in RCs can lead to them considering new meanings of recovery, challenging traditional recovery definitions, feeling more hopeful about recovery and increasing a sense of parity between staff and service users (Perkins *et al.*, 2017)

While studies have revealed people to be generally positive about RCs they have also raised various issues including questioning how to quality control trainers (Meddings *et al.*, 2014b), a lack of broad awareness of the potential positive impacts of RCs (Zabel *et al.* 2016) and some staff feeling that only certain people on their caseload could engage in a RC (Rinaldi and Suleman 2012)

Importance of research

Prior studies have highlighted a need for more qualitative studies to understand the process of change RCs involve as well as how RCs impact staff attitudes, motivation and the ethos of organisations (Meddings *et al.*, 2015b, Zabel *et al.*, 2016, Perkins *et al.*, 2017). Through questionnaires previous research has explored the attitudes of NSFT staff whom had been students at the RC (Perkins *et al.*, 2017) and therefore may have already shared the RC ethos. There has been no research exploring in more depth, through interviews, the views of staff whom have had minimal experience of RCs. This research therefore offers insight into prior conceptions of RCs.

Traditional approaches tend to assume knowledge and expertise belong to the professional (Meddings *et al.*, 2015b) however the RC model challenges this - involving a shift from the traditional power of professionals to a partnership of equals. Within RCs the professional and service user are on an equal plane both in terms of co-production of courses and as students (Meddings *et al.*, 2015b, Hans 2013), they reduce barriers between clinicians and services users (Zabel *et al.*, 2016, McGregor *et al.*, 2014) leading to increased parity (Perkins *et al.*, 2017), ultimately questioning the 'us and them' culture (Skipper and Page 2015, Zabel *et al.*, 2016). The RC demonstrates a dramatically different power relationship, which is crucial component of the success of RCs (Meddings *et al.*, 2015b). This change in relationship may be a particular challenge to psychiatrists, given that they are at the top of the clinical hierarchy. This study is unique in that it explores the views and attitudes of a specific staff group, psychiatrists, who are likely to be particularly influential within services.

One of the challenges RCs face is the risk of absence of professional experience, which is essential as this also brings evidence-based understanding (Perkins and Repper 2017), therefore it is important for psychiatrists to be positively engaged with RCs. For RCs to be successful they need strong organisational support, with senior support being vital (Zucchelli and Skinner 2013). The attitudes of professionals can have a significant impact on the extent to which people feel engaged and supported in their care, self-management and recovery journeys (Rinaldi and Suleman 2012). Gaining insight into the views psychiatrists hold about RCs will enable a better understanding of the organisational challenges RCs face.

The interviews in this study were conducted three months after the first two RC cohorts completed courses in September 2014, with the NSFT RC was first piloted in September 2013 (Skipper and Page 2015). NSFT is committed to recovery-focussed practice and have been working to expand this ethos throughout the organisation (Skipper and Page 2015). This project is therefore particularly suited to exploring organisational change in the NSFT following the implementation of a RC.

This study aims to offer insight into the views and attitudes psychiatrists have about RCs. This staff group is of particular interest as they are influential within services. Exploring the views of a relatively unexposed sample will enable insight into how the RC is perceived conceptually as well as recognised benefits and challenges. This will also enable an understanding of the state of wider organisational support.

Methods

Ten interviews with psychiatrists were conducted between January and March 2015. A prior interview was conducted, as a pilot, concerning broader concepts of service user involvement and was not included in the final sample. Participants were recruited opportunistically through existing contacts of the researchers and through approaching attendees at a mental health conference. This sampling approach was considered appropriate as the aim of the study was to gain a general, but detailed, insight into this group and not to be representative of all psychiatrists. All interviews took place at participant's workplaces bar one which was held on university premises. Interview length ranged from 27 to 56 minutes with an average duration of 39 minutes. Interviews were semi-structured and covered a range of service user involvement initiatives including RCs. Pre-set questions were asked along with further exploratory questions to expand upon answers. Participants were asked about their experience of RCs as well as definitions, advantages, disadvantages and the future of RCs. An extensive literature review on service user involvement was undertaken prior to conducting interviews to inform the question format.

To ensure a similar style, structure and pace all interviews were conducted by the same researcher. A reflexive journal was utilised, which enabled awareness of the researcher's values, interests, prior preconceptions and reflections on interviews as well as noting any non-verbal observations.

A thematic analysis approach was employed to identify, analyse and report patterns within the data set, this was informed by Bruan and Clarke (2006). This approach is especially suited to interpreting the conceptualisation of a phenomenon by a specific group (Joffe 2012). NVIVO was used as a data management tool to generate initial codes and sub-codes, these were subsequently grouped into themes. Themes were determined by considering both prevalence in the data as well as capturing important topics in terms of the study's aims. In addition, queries were run using NVIVO to generate word frequencies. The themes were reviewed by two other researchers in relation to both the codes and entire data set. This study has had ethical review from the Faculty of Medicine and Health Ethics Committee at the University of East Anglia.

Sample

All participants were medically qualified psychiatrists at consultant level except for one who was a speciality registrar and another who was a core trainee. Participants had an average of 15 years experience in psychiatry. Six interviewees were female and four male. Seven respondents were currently working in general adult services, but prior specialties of working in the specialties of old age, forensic, early intervention, learning disabilities, young people's mental health and child and adolescent mental health services (CAMHS) were all represented. None had been directly involved in a RC. All were familiar with the concept of RCs, seven had referred service users to a RC and four had met service users involved in a RC.

Results

Through analysis the following themes were identified; service user involvement, the RC model, benefits of RCs, challenges for RCs, the RC demographic and the future of RCs.

Service user involvement

Interviewees generally viewed RCs as a form of service user involvement, which some associated with IMROC and a government drive towards increasing such initiatives. The word 'involvement', and its derivatives, featured very frequently in interviews.

"There has been more of a focus on service user involvement for a long time and it may have come out of that. I am thinking about the charitable organisation that the government consult with...they will be saying there needs to be more emphasis on what the service user wants." (10)

One individual questioned the authenticity of such involvement:

"It is part of the same context of people becoming more involved and more empowered or appearing to be in a political sense such as government websites and people being able to send queries make you feel more involved, whether or not you are actually more involved." (3)

Throughout all interviewees there was a strong sense of multi-disciplinary involvement in RCs with eight out of ten interviewees referring to people from a variety of backgrounds being involved. Six interviewees referred more specifically to the co-production approach that RCs employ with service users and health care professionals working alongside each other:

“I guess the key benefits are you can attend with a family member or a friend which can be really useful for people, that is co-facilitated and you get to share learning between professionals and service users so you learn from each other, which is a really good approach.” (11)

While co-production was strongly acknowledged, many interviewees spoke of the importance of RCs ultimately being service user led:

“RC is a simple example of that, towards the service user being leading and responsible for part of their recovery rather than a more clinician led symptom focused model of treatment” (2)

The RC model

Many felt the perspectives of service users and the value of sharing lived experience were central to the RC model. The word ‘experience’ and its derivatives featured frequently throughout the majority of interviews. Four respondents suggested that RCs may help develop greater insight and offer new perspectives and ideas on recovery. Four different interviewees referred more directly to the educational ethos of RCs and the availability of workshops:

“I think the lived experience is what’s important within RC so it’s not just making use of the professional experience but also personal experience of mental health and mental illness and recovery and treatment” (6)

Two interviewees expressed some apprehension about RCs forming a movement away from the medical model, especially in terms of stopping medication. Three other interviewees acknowledged this as possibility but viewed it positively, whereby service users are more empowered to find out what works for them and benefit from a model that goes beyond medication:

“The anti-psychiatry movement don’t see drugs as the be all and the end all and the cure and I agree that it’s not necessarily the cure, it may help but certainly the side effects can make people’s lives as miserable as well. So I think it’s about people finding out what works for them so if the RC or any program helps people to find a better balance and way of managing that sounds great.” (4)

On the other hand, one interviewee felt that the RC model follows the same philosophy as therapeutic treatments:

“my opinion of course is that actually the idea of the RC is actually inbuilt within any of the therapies in a way if you think about it because if you’re talking about CBT there always an element of education and an element of therapy.” (5)

All agreed that RCs should be complementary to existing services and not a means of replacing some of them. Some felt that there needed to be a balance between people accessing RCs as well as other support. Some spoke of a need to encompass RCs more as part of what services have to offer:

“staff worry that it will be a replacement for other services, its critically important in terms of all these initiatives that’s it’s an additional rather than instead of something people need.” (3)

Benefits of RCs

The vast majority of interviewees were positive about RCs, with three interviewees standing out as particularly keen on their implementation. No interviewee appeared especially negative towards RCs, but two interviewees remained neutral. Optimistic words such as 'good', 'benefit' and 'positive' featured more frequently throughout interviews when compared to pessimistic words such as 'concern', 'difficult' and 'negative'.

The empowerment of service users was a reoccurring theme throughout with four interviewees referring specifically to empowerment and eight referring to this or related ideas such as increased autonomy, building personal strengths, greater control or power. Many felt positive about RCs as a way for service users to take more responsibility for their mental health and recovery. Three interviewees also specifically mentioned RCs as inspiring hope:

“Sometimes people come in and think I will have the answers and I don't. So I think it's for people to realise that they have the answer or bits of the answer together..... Also if service users have more control of it they can shape it in a way that suits them, we can learn from that and apply elsewhere in services.” (3)

Four believed there would be social functioning benefits, suggesting RCs can help improve the quality of life through social connections, linking people to the local community and preventing social isolation as well as combating social problems:

“people might be at similar levels of social disadvantage or have social problems with their life so when attending the college if you are in a group of people who might be in a similar situation to you, you might be able to find your way out and achieve what you want to achieve.” (6)

Two interviewees stated RCs may be more acceptable to the service user as they are tailored towards their needs:

“I think it is more acceptable by them because they have the responsibility to look after themselves so I feel in a way it is more compatible.....it's more self-directed so they accept it quickly” (9)

Two also viewed RCs as a good preventative measure as they may promote self-awareness, help sustain progress and offer earlier contact with services:

“We need to focus more on preventing relapse rather than thinking about when that patient has a relapse, we should be focusing trying to promote their progress, trying to sustain progress and reduce relapse. And I think RC works well towards that.” (7)

Challenges for RCs

In the context of wider cuts to NHS mental health services, while interviewees were broadly very positive towards RCs, five raised concerns over whether RCs may be a form of cost cutting by trying to reduce the demand on other services:

“I think the concern is that it was a way of cutting.....RCs can mean we don't have to see people as much, I suppose that is everyone's fear.” (2)

One interviewee welcomed the cost-efficiency provided by the RC approach:

“another benefit is as we have less and less time and resource, it could be another way of people getting, hopefully, meaningful input that doesn’t take as much expensive time and they could develop more themselves.” (3)

Four interviewees raised concerns about how RCs would be risk assessed and the potential difficulties of safeguarding vulnerable people. One felt this was particularly relevant to young people’s services where they had experienced unhelpful relationships being made between young service users. Another interviewee raised the potential risk of ‘bad teachers’, raising the question of how RCs are quality controlled:

“I would think the people who are involved in recovery are vetted quite well but you’ve got quite a vulnerable group of people going through those colleges I would think and being aware of that.” (8)

Two interviewees also mentioned the risk of potentially sharing unhelpful messages through the RC. Similarly, one interviewee felt meanings could be lost when trying to make things overly inclusive:

“Some of the messages might be inadvertently given to the patients by other people’s experiences, for instance they were better without seeing the doctors and having this or that medication. And sometimes people can be easily swayed by those lived experiences.....I am not saying that would happen in every case but it’s something to be wary of.” (6)

Some interviewees raised logistical challenges such as the non-central location of the RC, transport for service users and one felt RC sessions weren’t offered frequently enough. In addition to this some raised concerns about relying on unwell people to run the RC, problems with high patient turnover and questioned whether service users who have recovered would still want to be involved in mental health services.

“anymore reliance on ex-service users or professionals with lived experience of mental illness might put too much pressure on individual to lead or do something else. I would be concerned that they might suffer from trying to push the service forward which isn’t their remit.” (6)

Three also considered whether stigma might prevent people from becoming involved in RCs, on the other hand one interviewee suggested service users might want to become involved to combat stigma:

“Because we still have the stigma, it is not completely clear. We had a patient yesterday who was so keen, he said I just want to get involved because I know there is a stigma.” (9)

The RC demographic

Six interviewees referred to personal challenges service users may face when accessing RCs including anxiety, insight, personal motivation, being organised enough, personality factors, type of illness, stress levels and commitment. Similarly, four interviewees considered that some service users might face difficulties when trying to participate in a group or be unable to tolerate a group setting. Two interviewees suggested some service users might need a lot of practical or emotional support to be able to attend a RC:

“It’s quite difficult to go, if you’re a person with quite poor motivation because you’re depressed, or have psychosis, for someone to tell you to go away, go on the internet, remember what it’s called, get a book, is quite

a lot really isn't it. It does need some thinking about it and helping them to apply, I haven't got time to do that but the support workers may have time." (2)

Six interviewees considered RCs as most suitable for those who have been in services for a long time, have recently been discharged from inpatient care or for those with more enduring mental health problems. One person suggested RCs may be most accessible to those at the milder end of disability. Three interviewees stated RCs weren't suitable for everyone, such as during acute illness. Only one interviewee explicitly stated RCs are for everyone including staff and in addition felt RCs are particularly suited to individuals from a teaching or academic background:

"I think it [RC] is...a useful thing to have, but not what all service users will need and in some ways it has been sold like that in the trust, not everyone will go to a RC. I think it is a really good resource. (11)

One interviewee felt that RCs were not suited to individuals who had not accepted their illness whereas another suggested that RCs were a helpful means by which individuals can learn to take more responsibility for their mental health:

"I have seen patients who were on the ward and quite unwell, not taking responsibility for their condition and lacking knowledge despite attempts to give them information... Those patients who attend the RC I have seen a strong change in them, they become more responsible for their mental health and not blaming professionals or family for their condition and understanding they can help themselves and they are the best person to help themselves, happy to take that responsibility." (7)

The future of RCs

Most interviewees felt RCs have a firm place in the future development of mental health services. Five believed the RC model will continue to expand, with one stating they felt it would be the 'in' thing in the future. While generally optimistic about the future of RCs, three raised the need to determine an evidence base for RCs. Some suggested more funding might be required for RCs to become successful as well as a need for wider promotion and recognition.

"I think RCs are here to stay and will form and expand over time and with experience they will learn what is important and what will help people., I think it will move forward, I hope it does." (2)

Discussion

Despite their limited experience of RCs the psychiatrists in this sample were generally very positive about RCs, citing a number of benefits as well as a broad understanding of what RCs are. Indeed, all of the 'transformative powers' that IMROC identify were recognised throughout interviews; enabling people to become experts in their own care, co-production, breaking down stigma, providing peer support, decreasing isolation, having control and self-determination and promoting participation in the local community (Perkins *et al.*, 2012). This demonstrates that the RCs principles and values are very much shared and understood by this sample of psychiatrists. It has been reported that participation or exposure to RCs can change staff attitudes and behaviours (Zabel *et al.*, 2016, Rinaldi and Suleman 2012), which raises the question whether psychiatrists who have experienced RCs would be even

more positive than this sample. These results also contrast with Zabel *et al.* (2016) findings that there can be a general lack of awareness of the potential positive impact of RCs. In terms of the broadly positive outlook on RCs the findings of this study align with other research on people's views including RC students, care co-ordinators and other NHS staff (Meddings *et al.*, 2014b, Perkins *et al.*, 2017, Zabel *et al.*, 2016, Rinaldi and Suleman 2012).

Throughout interviews there was a strong sense of multi-disciplinary involvement in RCs, with co-production featuring less prominently. Ultimately it seemed interviewees viewed RCs as being service user led and not necessarily something that they would access themselves as a resource. This contrasts with two defining features of RCs; co-production and the RC being for everyone (Perkins *et al.*, 2012). While co-production was generally acknowledged the concept of co-learning was overlooked. This may reflect the limited exposure of this sample to the RC given that NSFT RC been relatively successful in recruiting students from both professionally qualified and non-professionally qualified backgrounds, compared to other RCs (Perkins and Repper 2017). Additionally, studies have revealed that RC students (including from healthcare professional backgrounds) value co-production (Zabel *et al.*, 2016, Perkins *et al.*, 2017).

Interviewees valued the sharing of both lived and professional experience, recognising this as a central part to the RC model, similar to prior research (Zabel *et al.*, 2016, Meddings *et al.*, 2014b). However, there was little mention of the RC role in transforming relationships between service users and professionals, or breaking down the expert/patient divide, a regular theme in the RC literature (McGregor *et al.*, 2014, Zabel *et al.*, 2016, Perkins *et al.*, 2012). This is of particular interest as the shift from the traditional power of professionals to a partnership of equals is a central component of the RC. This raises the question of whether there is a lack of understanding of this concept or a resistance towards what could be deemed as a loss of power.

There were some conflicting thoughts between interviewees about how the RC model interacts with the medical model. Some felt concerned about people rejecting medication while on the other hand some felt positive about individuals being empowered to find out what works for them best. This appears to be a novel finding of this research and may relate to this study being the first to explore the attitudes of those solely from a medical background. All interviewees agreed that RCs should be complementary to existing services with some feeling the RC needs to be more integrated into services. While this risks the RC losing its principles and being engulfed into traditional models (Perkins and Repper 2017) it is important for RC not to be set apart to best assist people in their recovery as well as influence and transform the way in which services operate (Perkins and Repper 2017, Meddings *et al.*, 2015a, Meddings *et al.*, 2015b).

As in prior studies (Meddings *et al.*, 2014b, Zucchelli and Skinner 2013, McGregor *et al.*, 2014, Meddings *et al.*, 2015b), interviewees recognised a range of benefits of RCs including; empowerment, building on personal strengths, greater control/autonomy, taking on more responsibility, inspiring hope and improved social functioning. While there was an emphasis by some on the social benefits there was also an appreciation that RCs are unique in what they offer, they are not a form of day or activity centre. This is reassuring as lost meaning is a challenge that RCs face (Perkins and Repper 2017). The social benefits of RCs are widely

recognised (Meddings *et al.*, 2015b, McGregor *et al.*, 2014, Meddings *et al.*, 2014b, Zabel *et al.*, 2016). Additionally, the sample of psychiatrists felt RCs may be more acceptable to service users and thought they could be a good preventative measure.

Perkins and Repper (2017) state that many criticisms come from a misunderstanding of what RCs do however it can be argued that, despite this sample's limited exposure to the RC, they had a broad comprehension of the RC model. Nevertheless, concerns were expressed around practical aspects including funding, resource cutting and the physical location as well as the logistics of running a RC including risk assessment and safeguarding, the sharing of unhelpful messages and quality control. There are various arguments when it comes to the cost of RCs, with some arguing that RCs can be a 'win-win' by improving services and reaching more people for less (Perkins *et al.*, 2012, Meddings *et al.*, 2015a) and others worrying it may be a cheap alternative designed to cut costs (Perkins and Repper 2017). As Zucchelli and Skinner (2013) stated, the message needs to be clear throughout services that the college is for everyone's benefit and not a replacement of traditional treatment. The logistical challenges of where to locate a college, travel factors, suitability of venues and timetabling have been raised by other studies (Perkins and Repper 2017, Dunn *et al.*, 2016, Meddings *et al.*, 2015a, Zabel *et al.*, 2016). Prior research has limited insight into the concerns raised by this sample including the sharing of unhelpful messages, the potential difficulties of relying on people who might be too unwell to run the RC and how RC works in relation to stigma. One prior study (Meddings *et al.*, 2014b) did raise the question of how to ensure trainers are skilled in teaching, which was a query by one interviewee.

Interviewees generally considered RCs as most suitable for those in services for a long time, and who are at a certain point in their recovery journey, with some implying they recommend it to certain people more than others. To an extent this conflicts with RC literature which states RCs should be for everyone (Perkins *et al.*, 2012) and some argue that RCs can be made more accessible by creating a 'safe space' (Zucchelli and Skinner 2013). It is widely agreed there should be no selection or referral of people to RCs based on professional judgement (Perkins and Repper 2017, Zucchelli and Skinner 2013, Meddings *et al.*, 2015b). The sample of psychiatrists recognised several boundaries to accessing RCs including individual factors such as anxiety, stress, illness and ability to tolerate a group.

Other research has recognised similar barriers such as anxiety, worry about group participation (Dunn *et al.*, 2016) and stage of recovery (Zabel *et al.*, 2016). Rinaldi and Suleman (2012) reported that care co-ordinators felt that only just over half of people on their caseload would be able to engage in a RC, however those that had been exposed to RCs had higher expectations of service users. Therefore, it could be argued that if this sample of psychiatrists were to have greater exposure to RCs, they might place less significance on these barriers.

Psychiatrists in this sample were optimistic about the future of RCs but some recognised a need for a more robust evidence-base, like many others (Perkins *et al.*, 2012, Dunn *et al.*, 2016, Meddings *et al.*, 2015b, Meddings *et al.*, 2014a). In an evidence-based NHS it can be argued that one of the greatest challenges the RC model faces is the lack of robust clinical evidence, ideally in the form of a randomised control trial. Nevertheless, comparable to Zabel *et al.*, (2016) findings, it can be concluded that a cultural shift is occurring with staff

feeling motivated by, and valuing, the RC model. As psychiatrists are likely to be influential within organisations it would be of interest to explore the views of those who had been involved in a RC to understand whether the same benefits and challenges are recognised or whether involvement transforms an individual's attitudes towards the RC model.

Conclusion

This study offers insight into the views of psychiatrists on the RC model. Psychiatrists generally had a strong concept of the RC model, citing all the transformative powers' that IMROC identify (Perkins *et al.*, 2012). Psychiatrists were broadly positive about RCs, recognising several benefits, and feeling optimistic about their future. Various challenges for RCs were also acknowledged. For the RC to be successful strong organisational support and involvement is required at all levels.

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