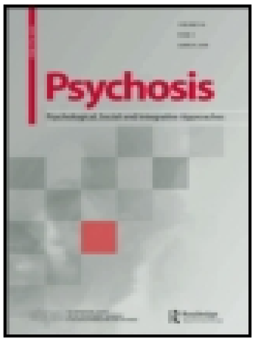

Psychosis

Psychological, Social and Integrative Approaches

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/rpsy20

A five-year prospective evaluation of a new community psychosis service in North London: introducing the Recovery and Enablement Track (RET)

James Hurley , Suzanne Jolley , Orla Gibbons , Aduramigba Williams , Satish Nath Varma , Suchi Bhandari , Kajori Mukherjee , Hilary Garraway , Cerys Jones , Narin Aker , Elizabeth Appiah-Kusi & Timothy Weaver

To cite this article: James Hurley , Suzanne Jolley , Orla Gibbons , Aduramigba Williams , Satish Nath Varma , Suchi Bhandari , Kajori Mukherjee , Hilary Garraway , Cerys Jones , Narin Aker , Elizabeth Appiah-Kusi & Timothy Weaver (2020): A five-year prospective evaluation of a new community psychosis service in North London: introducing the Recovery and Enablement Track (RET), Psychosis, DOI: 10.1080/17522439.2020.1803954

To link to this article: https://doi.org/10.1080/17522439.2020.1803954

Published online: 11 Sep 2020.

Submit your article to this journal

Article views: 17

View related articles

View Crossmark data

Full Terms & Conditions of access and use can be found at
https://www.tandfonline.com/action/journalInformation?journalCode=rpsy20

PSYCHOSIS
https://doi.org/10.1080/17522439.2020.1803954

Routledge
Taylor & Francis Group

Check for updates

A five-year prospective evaluation of a new community psychosis service in North London: introducing the Recovery and Enablement Track (RET)

James Hurley[a], Suzanne Jolley[b], Orla Gibbons[c], Aduramigba Williams[c], Satish Nath Varma[c], Suchi Bhandari[c], Kajori Mukherjee[c], Hilary Garraway[c], Cerys Jones[c], Narin Aker[c], Elizabeth Appiah-Kusi[b] and Timothy Weaver[d]

[a]Tower Hamlets Early Intervention Service, East London NHS Foundation Trust, London, UK; [b]Department of Psychology, Kings College London, London, UK; [c]Barnet, Enfield and Haringey NHS Mental Health Trust, London, UK; [d]Department of Mental Health and Social Work, Middlesex University, London, UK

ABSTRACT

Background and aims: United Kingdom mental healthcare guidelines recommend recovery-focused services for people with psychosis. We evaluated a "Recovery and Enablement Track" (RET) aiming to promote recovery and well-being, reduce distress and maintain independence from secondary care following discharge, for people with established psychosis and long histories of secondary care.

Method: From March 2015 to December 2019, 214 individuals entered the RET and were followed up 12 months' post-discharge. Recovery, well-being, and distress were measured at assessment, review, and discharge. Of 214 total people, 86 consented to inclusion for this evaluation.

Results: Well-being and recovery significantly improved from assessment to discharge – distress did not. Distress improved from review to discharge, suggesting improvement during service contact. 79% (68/86) of individuals were discharged to the care of their family doctor, and 22% of these (15/68) re-presented before 12-month follow-up.

Conclusion: Recovery and well-being improved from assessment to discharge, distress improved from review to discharge. Half of consenting participants were successfully discharged from secondary care following the RET, suggesting potential to promote recovery. Comparison to a formal control condition with systematic analysis of any biasing effect of missing data (i.e. through refusal to participate) is now indicated.

ARTICLE HISTORY
Received 18 May 2020
Accepted 28 July 2020

KEYWORDS
Recovery; community service evaluation; psychosis

Introduction

The Five-Year Forward View for Mental Health (United Kingdom (UK) National Health Service (NHS) Mental Health Taskforce, 2016) highlighted the need for psychosis services that focus on recovery, future planning and increased contact with non-clinical community services where appropriate, e.g. local charitable organisations. Recovery models highlight the importance of moving away from a primary focus on achieving and maintaining symptom remission through long-term care and monitoring, which potentially devalues personal resources and fosters dependency on services, toward a focus on personal strengths, well-being and resilience (Shepherd et al., 2008). There are many ways of understanding and defining recovery (e.g. Leamy et al., 2011). We drew from Anthony's (1993) definition of recovery " … as a deeply personal, unique process of changing

CONTACT James Hurley ✉ james.hurley1@nhs.net 🖃 Hamlets Early Intervention Service, London E2 6BF

© 2020 Informa UK Limited, trading as Taylor & Francis Group

one's attitudes, values, feelings, goals, skills, and/or roles … a way of living a satisfying, hopeful, and contributing life … " (pp. 527) alongside having a serious mental health condition.

Although awareness and promotion of recovery is expanding in the UK NHS, there remains a lack of research into recovery-focused services (Slade et al., 2014). Emerging evidence suggests that Recovery Colleges in the UK are satisfactory to use, improve recovery, well-being and hope (e.g. Ebrahim et al., 2018), and may help to engage those who find it difficult to use traditional services (e.g. Shepherd et al., 2014). Translating these principles into mental health services may promote more rapid and successful throughput for people with established psychosis, rather than long, potentially unhelpful, and cost-ineffective stays in secondary care. Secondary care mental health services in the UK are specialist multi-disciplinary community-based teams that sit between the family doctor and in-patient services. We therefore developed a "Recovery and Enablement Track" for two adult community mental health teams in the diverse outer London borough of Enfield, part of Barnet, Enfield and Haringey NHS Mental Health Trust (BEH).

Evaluation aims

This evaluation sought to establish whether the RET showed potential in promoting recovery, increasing psychological well-being and reducing distress, as measured by change in key outcomes from entry to exit, as well as promoting the attainment of personal recovery goals, and successful, collaboratively agreed discharge from secondary care.

Method

How the service was developed

The RET was a new community-based service for individuals with primary schizophrenia-spectrum or bipolar affective disorders, according to the working diagnosis of the treating team. It served two established community mental health teams (CMHTs) for adults aged 18 years and over (East and West Enfield). The primary objectives of the RET were to empower and enable clients to (a) secure and maintain a safe and supportive home, (b) acquire social capital through friends and relationships, and (c) achieve community integration with meaningful activity. The RET was designed for service users whose needs, as judged by the treating team, no longer necessitated the Care Programme Approach (CPA; a system for planning and monitoring care, usually reserved in secondary care for people with the highest levels of mental health need). It had been difficult to support discharge from the team for a variety of reasons including persisting clinical difficulties or lack of confidence in their ability to manage. In such cases, "maintenance" contact with a team is often offered, comprising prolonged, infrequent monitoring/review, that may promote disempowerment and dependency (Slade et al., 2014). The aim of the RET was to promote recovery and to facilitate discharge from specialist mental health services back to the care of their family doctor.

Inception

Early in 2015, clinicians, service users and carers, through a series of local borough meetings, agreed the core principles of the service (Table 1). Review meetings included people with lived experience, and feedback from carers groups was also used to shape the service as it progressed.

Funding

We obtained funding from the trust's enablement programme to recruit two Associate Mental Health Workers (AMHWs) at Agenda for Change Band 4 for each RET. Senior management agreed to allocate the extra funding specifically to help set up the RET in Enfield. With the rationale that

Table 1. Operating procedures of the RET linked to key recovery principles.

Key recovery principle	Standard for operating the RET
Promotion of independence	The RET is a time-limited way to support clients toward discharge to their family doctor and this should be made clear to them in their first assessment meeting
Length of time in service is client-led	Clients could choose between 6 months minimum and 12 months' maximum before trying discharge to their family doctor; this choice should be discussed in the initial assessment meeting
Focus on future goal planning	Client-set recovery goals at the beginning are an important part of the intake assessment
Emphasis on connection, based on clients' interests	Individual key working sessions should signpost and support the use of non-clinical community services as much as possible
Personal change and growth	A menu of recovery-focused psychology groups should be offered to all; clients can attend any they wish and as often as was helpful to them
Information on recovery, so clients can make informed choices for themselves	Materials including a welcome pack with information on local resources and some principles of recovery should be given

investment in the RET would help reduce CMHT caseloads in the longer term, trust managers also agreed the release of one full-time Band 7 Nurse Practitioner Lead and 0.5 WTE Clinical Psychologist at Band 7 to join the RET's staffing complement.

Operation

We examined CMHT caseloads for people who no longer needed secondary care in terms of the severity of their mental health presentation (indicated by having been stepped down from CPA), but who the team had not felt able to discharge at the point of stepping down. We approached everyone individually to discuss the RET, and with their agreement, transferred their care. Figure 1 details the flow of users in this pathway.

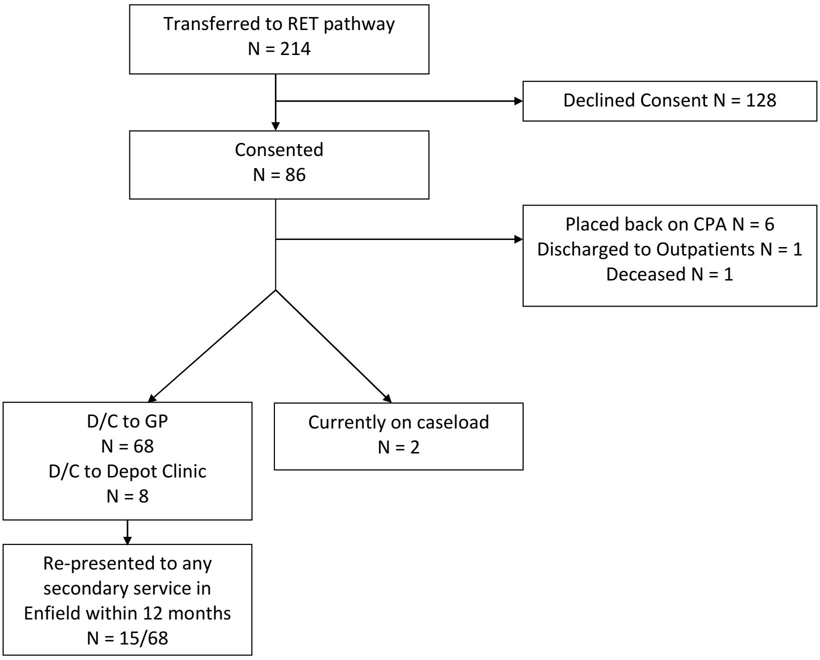

Figure 1. Flow diagram of Recovery Enablement Track clients who gave/declined consent for their measures to be analysed for the current evaluation. Note: RET – Recovery Enablement Track, CPA – Care Programme Approach, GP – Family Doctor.

All clients taken on to the RET were allocated a named keyworker from the above complement on a pro-rata basis; each full-time keyworker had a caseload of 30 clients. Once allocated, keyworkers contacted the client, explained the RET and offered a welcome meeting. At this meeting, they were given their welcome pack, which included information on recovery, strategies to support consideration of change and how to implement this, as well as practical information around budgeting, benefits, and signposting to local non-clinical community services. It also contained graphs, so clients could monitor their progress on their measures of recovery, well-being, and distress during their time in the RET. At this intake meeting, clients also considered goals they wanted to achieve through the RET. Measures were taken on recovery, well-being, and distress to inform care and to monitor progress throughout their journey in the RET (see measures section). The client and keyworker agreed to try a set time in the RET between 6 and 12 months followed by discharge to their family doctor. They also booked in review meetings at varying intervals and a discharge meeting where the measures were repeated, and progress discussed. Midpoints therefore vary according to duration of stay, e.g. for a client choosing 9 months, the midpoint review would be at 4.5 months, to repeat the measures and plan next steps.

RET interventions

Each RET offered recovery college-style courses based on the areas outlined in Table 2.

These courses were offered to all individuals and regular reminders of which courses were starting up next were given at keyworking sessions. Clients also had access to medical reviews with psychiatry colleagues and nurse prescribers as appropriate. With respect to ongoing clinical management, if concerns regarding mental state or needs arose at any time while a client was in the RET; there was the option of stepping up to the CMHT and being placed on CPA. If after time these needs lessened, clients could be stepped back down to the RET in a collaborative way.

Governance

The BEH NHS Trust Research & Development department approved this service evaluation. As such, it was linked to clinical governance and audit within the trust. The service followed local trust policies regarding managing care and safety and so structures were in place to manage any client or staff distress encountered during their time in the RET. Some examples of these protocols for client well-being included routine risk assessment, ongoing staying well planning, and frequent reviews. For

Table 2. RET courses offered to all.

Course title	Description
Recovery for unusual experiences	A 12-session course that gave information on unusual experiences and offered some strategies for self-management if these experiences lead to distress
Keeping your balance for bipolar	A 10-session course aimed at giving information around self-management of mood and distressing elation
Acceptance and Commitment Therapy for Recovery (Butler et al., 2015)	A new 6–8 session group intervention focused on boosting psychological flexibility as a mechanism of improving recovery for those who suffer from distressing psychosis
Carer's Courses	A 12-session course that gave a space for carers to reflect on their own situation, to promote self-care and improve carer wellbeing
CBT techniques for managing low mood and anxiety	A course that gave information on common emotional difficulties and that used cognitive behavioural techniques to promote self-management of these
Others (e.g. Assertiveness, self-esteem)	These courses were approximately 6 sessions long and focused on role play to practice skills to boost interpersonal effectiveness and self-esteem
Individual keyworking sessions	These were flexible appointments between client and keyworker and could focus on anything the client wished to bring, relevant to their recovery
Medication information sessions	These sessions were given by nurse prescribers and/or the nurse leads and were offered to carers and clients. General information was given around the major types of medications prescribed, followed by Q&A.

staff well-being, structures like regular clinical supervision and monitoring of workload were in place, as with all clinical services in BEH.

Sample size and definition

We aimed to recruit as large a sample as possible for consent to share their data for publication during the first 1.5 years of operation. All individuals referred to the RET were already under the care of either East or West Enfield CMHTs and were not on CPA. All 214 people who were offered a place in the RET between March 2015 and November 2016 were asked to give informed consent for their data to be analysed for service evaluation, that would potentially be published. From December 2016, we decided to stop seeking consent from anyone else referred to the service, due mainly to time constraints reducing capacity to collect more data. Eighty-six individuals signed a consent form and their data were included in the current evaluation.

Design and analyses

This evaluation focused on detecting any within-subject improvements from assessment to discharge within a naturalistic service setting with varying levels of engagement. We used a repeated-measures design, comparing data taken at assessment, review, and discharge to determine any change over time. The Shapiro–Wilk tests revealed some non-parametric data. Therefore, repeated measures of more than two observations were analysed using Friedman's ANOVA. Post hoc analyses were conducted, and effect sizes derived using Cohen's d with confidence intervals, because we were unable to calculate 95% confidence intervals for r. Binary repeated data of two observations, i.e. re-presentation rates to secondary services, were analysed using McNemar's test. All other data were conveyed as descriptive statistics.

Missing data

As with naturalistic service evaluations, there were large proportions of missing data. We reported and treated missing data according to the convention developed and recommended by Manly and Wells (2014). Their recommendations relevant to our analysis were to 1. report rates of missing data, 2. provide known reasons for missing data, and 3. test for evidence of ignorable patterns of missing data. Rates of missing data were reported in Table 5. The main reason for missing data was due to attrition within the service. However, Little's Missing Completely at Random test ($\chi^2 = 72.42$, df = 65, p =.25), suggested that attrition might not have affected data loss in a systematic way. It is also possible, however, that this analysis was underpowered.

Measures

We used the following outcome measures as both clinical assessment and as evaluation data:

*1. The Recovery Star (*Triangle Consulting Ltd. & the Mental Health Providers Forum, 2008)

This is used for personal recovery planning and monitoring progress and is helpful for identifying personal goals (Shepherd et al., 2014). Ten areas of recovery are each rated from 1–10; higher ratings suggest improved recovery. We used a total score out of 100, across all domains, to measure recovery.

2. The Warwick-Edinburgh Mental well-being Scale (WEMWBS; Tennant et al., 2007)

We measured general psychological well-being with the WEMWBS, which has reported good psychometrics for individuals using secondary care services in the UK (Bass, Dawkin, Muncer, Vigurs & Bostock, 2016). It ranges from 14–70, with higher scores indicating increased well-being. Total scores out of 70 were used to monitor well-being in the RET and for the current evaluation.

*3. The CORE-10 (*Barkham et al., 2013)

Table 3. Clinical and demographic characteristics of consented participants (N = 86), those who declined consent (N = 128), the difference between both groups, and the whole cohort (N = 214) expressed as percentages.

Characteristic	N = 86	% of N = 86	N = 128	% of N = 128	Difference (M-WU) *p*=	N = 214	% of N = 214
Median (IQR) age in years	45 (36–53)		45 (37–53) *		.869	45 (36–53) *	
Female/Male	43/43	50%/50%	76/54	58%/42%	.222	118/98	45%/55%
Asian Other or Asian British	11	13%	14	10%	.717	25	11%
Black Other or Black British	16	19%	23	17%	.717	39	18%
White Other or White British	50	58%	80	63%	.717	130	61%
Other ethnic group	9	11%	13	10%	.717	22	10%
Schizophrenia-spectrum disorder	52	65%	80	62%	.751	132	61%
Bipolar affective disorder	23	27%	37	28%	.751	60	28%
Mood or personality disorder	7	8%	10	8%	.751	17	8%
Other diagnosis	4	5%	3	2%	.751	7	.03%
Median (IQR) length of difficulties in years	8 (5–12) *		8 (5–13) *		.848	8 (5–13) *	
N available data for length of time in RET	79	92%	111	87%		190	89%
Median (IQR) length of time in RET in months	13.5 (9–22)		11 (7–14)		.025	12 (8–16)	

M-WU – Mann-Whitney U, IQR – Inter-Quartile Range, * – N = 1 missing data, RET – Recovery Enablement Track.

Table 4. Descriptive statistics, paired comparisons, and parametric effect size estimates for all original data, broken down by team[1].

Measure	Time point	N (missing)	Median (IQR)	Min-Max	Mean	SD	(N) *d* (95% CI)
East Recovery Star	1	45 (3)	66 (58–77)	35–100	65.58	14.62	(39) T1vT2 =.25 (–.07 –.57)
East Recovery Star	2	39 (9)	74 (56–79)	26–100	69.08	15.44	(30) T1vT3 =.27 (–.09 –.63)
East Recovery Star	3	30 (18)	72 (54–84)	29–100	69.43	18.40	(22) T1vT4 =.93 (.42–1.42)
East Recovery Star	4	22 (26)	78 (65–86)	49–95	75.46	13.46	(30) T2vT3 =.03 (–.33 –.39)
East WEMWBS	1	40 (8)	44 (38–52)	18–70	45.25	11.06	(36) T1vT2 =.33 (–.01 –.66)
East WEMWBS	2	37 (11)	49 (43–54)	36–70	48.89	8.2	(29) T1vT3 =.32 (–.06 –.69)
East WEMWBS	3	30 (18)	47 (40–55)	35–70	48.60	9.26	(21) T1vT4 =.34 (–.11 –.77)
East WEMWBS	4	22 (26)	50 (46–54)	32–67	49.82	7.69	(29) T2vT3 =.07 (–.29 –.44)
East CORE	1	32 (16)	11.5 (7–17)	2–28	12.41	7.01	(29) T1vT2 =.43 (.04 –.8)
East CORE	2	35 (13)	15 (07–12)	0–24	11.66	5.78	(24) T1vT3 =.02 (–.38 –.42)
East CORE	3	28 (20)	12 (07–15)	0–24	12.25	6.72	(16) T1vT4 =.39 (–.12 –.9)
East CORE	4	21 (27)	8 (04–14)	0–27	9.52	7.02	(28) T2vT3 =.17 (–.2 –.55)
West Recovery Star	1	34 (4)	57 (56–77)	43–98	67.91	14.89	
West WEMWBS	1	37 (1)	44 (36–56)	22–70	44.46	13.3	(25) T1vT2 =.37 (–.04 –.77)
West WEMWBS	2	25 (13)	47 (38–55)	22–68	46.96	11.46	(16) T1vT3 =.74 (.18–1.29)
West WEMWBS	3	16 (22)	51 (48–62)	35–70	52.38	9.57	(16) T2vT3 =.47 (–.06 –.98)
West CORE	1	37 (1)	14 (09–22)	0–35	14.65	9.29	(25) T1vT2 =.08 (–.31 –.48)
West CORE	2	25 (13)	13 (10–19)	4–29	14.16	6.5	(16) T1vT3 =.24 (–.27 –.73)
West CORE	3	(16) 22	8 (5–18)	0–30	10.81	8.18	(16) T2vT3 =.54 (.01–1.06)

N – sample size for each given time point, IQR – Inter-Quartile Range, SD – standard deviation, *d* – effect size with CI – 95% confidence intervals, T1vT2 – time point 1 compared with time point 2, etc., WEMWBS – Warwick-Edinburgh Mental Wellbeing Scale.

[1] In the West RET, the recovery star was administered at the intake assessment only, due to the local team being of the view that further recovery star assessments were not required. Therefore, we decided to exclude West RET recovery star scores and analyse East RET recovery star scores alone. Measures on wellbeing and distress were collected at three time points in the West RET because clinicians believed measures at assessment, review and discharge were sufficient. In the East RET, scores were obtained on recovery, wellbeing, and distress at four time points throughout the RET: assessment, two reviews and at discharge. Data on wellbeing and distress were gathered in West and East RET and pooled for analysis. To pool data, we omitted scores on recovery, wellbeing and distress in East RET for time point number 3. The reason for omitting this time point was that there was no difference between time points 2 and 3 on any of the three measures, and so it would not influence the analysis.

We measured general psychological distress with this popular, well-validated and normed measure for adult samples (Barkham et al., 2013). Ranging from 0–40, higher scores indicate increased distress. We used total scores out of 40 to monitor distress within RET and for this evaluation.

We asked clients at their discharge meeting whether they were happy with discharge to their family doctor, recorded as a yes or no response. This was intended to act as a brief measure of satisfaction with the service as well as agreeing with the planned discharge. We recorded number of recovery goals set at entry and number of goals achieved at exit. We measured length of time from discharge to re-presentation to secondary mental health services in Enfield by counting 12 months from the discharge date and interrogating the clinical notes to determine if any referrals had been received within that time. We collected demographic and clinical information from client notes.

Results

Table 3 gives demographic and clinical characteristics of the sample correct at the date of intake. Mann-Whitney U tests were conducted on all interval, ordinal and binary data in Table 3. The above table shows no significant differences between the samples, except for median length of time in the RET, which was significantly higher in the group who gave consent. This led us to assume that both groups were comparable, and so analysis of the sub-sample of those who gave consent could be generalised back to the larger cohort. However, it is possible that this analysis was underpowered. Table 4 provides data on recovery, well-being, and distress for East and West RET individually.

Table 5. Descriptive and inferential statistics of recovery, wellbeing and distress measures showing change from assessment, to review and discharge.

Measure	N (missing)	% available for analysis	Median (IQR)	Min-Max	ANOVA Median (IQR)	χ^2	*p*	Median (IQR)	Post hoc *d* (95% CI)
East Recovery Star – Assessment	45 (3)	93.8	66 (57–77)	35–100	63 (54–77)	15.721	.000	A = 66 (57–77)	AvR = 0.27 (−0.1–0.64)
East Recovery Star – Review	39 (9)	81.3	74 (55–79)	29–100	75 (53–89)	15.721	.000	R = 72 (54–85)	AvD = 0.93 (0.42–1.42)
East Recovery Star – Discharge	22 (26)	45.8	78 (64–86)	49–95	78 (64–86)	15.721	.000	D = 78 (64–86)	RvD = 0.52 (0.07–0.96)
WEMWBS – Assessment	77 (9)	89.5	44 (37–54)	18–70	45 (40–53)	6.431	.040	A = 47 (40–55)	AvR = 0.35 (0.07–0.62)
WEMWBS – Review	55 (31)	64	47 (40–55)	22–70	47 (40–57)	6.431	.040	R = 48 (40–56)	AvD = 0.46 (0.12–0.79)
WEMWBS – Discharge	38 (48)	44.2	51 (47–54)	32–70	50 (47–55)	6.431	.040	D = 51 (47–54)	RvD = 0.33 (−0.01–0.65)
CORE – Assessment	69 (17)	80.2	13 (7–19)	0–35	11 (7–15)	8.81	.012	A = 13 (8–19)	AvR = 0.26 (−0.02–0.53)
Core – Review	60 (26)	69.8	13 (9–17)	0–29	13 (9–15)	8.81	.012	R = 13 (10–16)	AvD = 0.31 (−0.05–0.66)
CORE – Discharge	37 (49)	43	8 (5–15)	0–30	8 (4–14)	8.81	.012	D = 8 (5–15)	RvD = 0.47 (0.12–0.81)
All variables		67.49							

N – sample size, IQR – Inter-Quartile Range, ANOVA – Friedman's test for 3 time points, χ^2 – Chi-Square, *p* – alpha, *d* – parametric effect size with CI – 95% confidence intervals, *A* – Assessment, R – Review, D – Discharge, AvR – Assessment compared with Review, AvD – Assessment compared with Discharge, RvD – Review compared with Discharge

Table 5 outlines the pooled data across both East and West RET. It also gives characteristics of the missing data and the descriptive and inferential statistics of the original data with varying rates of missing observations. The results address the evaluation questions focused on improved outcomes and successful discharge.

Improved outcomes

Table 5 indicates that in East RET, the size of increased recovery star scores between assessment (Mdn = 66, IQR = 57–77) and review (Mdn = 72, IQR = 54–85) was non-significant (*d* (95% CI) = 0.27 (−0.1–0.64)). Size of increase in recovery star scores comparing assessment with discharge (Mdn = 78, IQR = 64–86) was large (*d* (95% CI) = 0.93 (0.42–1.42). Increase between midpoint review and discharge was medium (*d* (95% CI) = 0.52 (0.07–0.96).

In terms of psychological well-being, Table 5 indicates a small sized effect in increased well-being scores (*d* (95% CI) = 0.35 (0.07–0.62)) comparing assessment (Mdn = 47, IQR = 40–55) with review (Mdn = 48, IQR = 40–56). Comparison of assessment with discharge (Mdn = 51, IQR = 47–54) found a medium sized effect in improved well-being (*d* (95% CI) = 0.46 (0.12–0.79)). No effect existed between review and discharge (*d* (95% CI) = 0.33 (−0.01–0.65)).

With respect to psychological distress, Table 5 shows no effect (*d* (95%CI) = 0.26 (−0.02–0.53)) when comparing distress scores at assessment (Mdn = 13, IQR = 8–19) with those at review (Mdn = 13, IQR = 10–16). Comparison of assessment with discharge (Mdn = 8, IQR = 5–15) revealed no effect in reduced distress scores (*d* (95% CI) = 0.31 (−0.05–0.66)). Distress scores significantly improved when comparing review with discharge (*d* (95% CI) = 0.47 (0.12–0.81). In conclusion, we found no significant difference between distress scores recorded at assessment and discharge. However, the positive difference observed between the distress scores at review and discharge timepoints indicate that distress may nevertheless have been reduced during contact with the service. This requires further investigation.

Focusing on proportion of achieved recovery-focused goals, data on goals were available for 37 people. Total goals set at assessment were 84 (range = 0–6) and total achieved goals at discharge were 57 (0–5), which represents 68% successful completion of goals. Analysis using the Wilcoxon test revealed significantly less goals achieved by the time of discharge (Mdn = 1, IQR = .5–2) compared with total number of goals set at assessment (Mdn = 2, IQR = 1–3, $Z = -4.093$, $p = .000$).

Successful discharge

We evaluated how many clients were happy to be discharged at the agreed point of discharge. Of the 67 individuals discharged to their family doctor, available data on 52 individuals showed that 50 reported being happy with discharge at the agreed time. Two respondents reported not being happy with discharge. These high rates indicate good overall satisfaction with the service, based on the available data.

We also examined whether those clients who were discharged to their family doctor achieved independence from secondary mental health services for 12 months after discharge from the RET. Six individuals were stepped up to CPA, eight were discharged on to the depot clinic, two people are still in the RET planned for discharge soon, one person was placed back into outpatients, and one person sadly died while in the RET. This leaves 68 out of 87 people discharged to the care of their family doctor. Of those 68 people, a total of 15 individuals re-presented to secondary services within 12 months follow-up, which was in the significant minority according to McNemar's test, $p = .000$.

Finally, we investigated whether there was any difference between length of previous contact with secondary care mental health services and time spent in the RET. Length of time in months under secondary care prior to entry (Mdn = 21, IQR = 5–51) was significantly higher than time in the RET itself (Mdn = 13.5, IQR = 9–22; $Z = -3.318$, $p = 0.002$, $r = -0.36$, d (95% CI) = 0.79 (0.55–1.03)).

Discussion

Our study was a naturalistic evaluation of a recovery-focused service, implemented for the first time in Enfield community psychosis services. The aims of this evaluation were to determine whether the RET

(1) Promoted recovery, improved well-being, reduced distress, and
(2) supported discharge to the care of the family doctor, and independence from specialist mental health services for 12 months.

The main findings of this evaluation suggested that, of the 68 out of 87 people discharged to their family doctor, a significant minority (N = 15, $p = .000$) required secondary mental health services in Enfield within 12 months of discharge. Time spent in secondary care prior to the RET was significantly longer than time spent in the RET. The majority of those for whom there were available data reported being happy to be discharged to their family doctor at the time of discharge (N = 50/52). The current evaluation also indicated an improvement in recovery and well-being from assessment to discharge, and distress from review to discharge, with small to medium effect sizes. Finally, this evaluation measured the proportion of recovery-focused goals set at entry to the service that were achieved by the point of discharge. Fifty-seven out of 84 goals were reported to be achieved, which was significantly fewer goals than those set at entry ($p = .000$).

The above findings fit with evidence that recovery-focused interventions in community mental health services have led to improved recovery and well-being. Slade et al. (2014) reviewed the evidence for recovery-specific interventions including wellness and recovery action planning (WRAP). This involves guiding individuals and groups to reflect on what has facilitated their recovery and WRAP informed practice within the RET. A randomised wait-list controlled trial of WRAP among 519 people with established psychosis demonstrated significant improvement over time in distressing positive symptoms, hopefulness, and quality of life (Cook et al., 2012). Illness management and recovery is another established approach to teaching self-management strategies that was also drawn from within the RET. This has been shown to improve recovery and quality of life (e.g. Färdig et al., 2011), in keeping with the findings from the current evaluation. Also adopted in the RET was the strengths model, which helps clients to consider the resources they need to achieve their own recovery goals. Slade et al. (2014) note several studies indicating improved symptoms, social functioning, and client satisfaction, which do not translate directly to our evaluation, making contextualisation difficult. It seems that, due to the personal nature of recovery, further research is needed to examine outcomes that can directly compare across studies for recovery-focused community mental health services for people with psychosis.

Study strengths and limitations

There were several limitations to the current evaluation. BEH Research and Development approval restrictions to the service evaluation protocol stipulated no follow-up contact to people who had been discharged from the RET to primary care. This meant relying on the clinical record to determine whether they had been referred by their family doctor to secondary mental health services. It is possible that a proportion of clients moved out of area, etc., within the 12-month follow-up period, weakening confidence in the findings. However, this was the only approximation of re-presentation rates available to the authors.

The repeated-measures design means potential inflation of effect sizes. Therefore, as with all non-controlled studies, these results should be interpreted with caution. As a local service was evaluated, the results may not generalise beyond this setting. Risk of bias was introduced into the evaluation due to many factors, including high rates of missing data, loss to follow up assessment, small sample sizes and underpowered analyses. It is unclear specifically why such low rates of data around goal completion were collected, but this does limit the conclusions that can be drawn from analysis of completed goals during service contact. Less than half (40.2%) of all who availed of the RET gave consent for their data to be published. This does introduce potential bias into the findings, due to the sample potentially not being representative of the whole cohort in terms of either engagement with the service, or improvement in their measures. What hopefully has helped to mitigate this somewhat was use of confidence intervals with effect sizes. However, increasing the sample size to 100% of the cohort would certainly have helped increased confidence in the findings, due to increased statistical power, as well as a more representative sample of this first RET cohort.

This evaluation had increased risk of bias due to diagnoses and need for CPA being determined by the treating team rather than by objective criteria and the limitations of self-reported measures without corroborating data. Service satisfaction was measured indirectly by asking if clients were happy with discharge to their family doctor, which may not concord with satisfaction. A scale of service satisfaction could be used in future evaluation. High caseloads of 30 clients per keyworker might have impacted negatively on outcomes; future comparison with smaller caseloads could potentially test this.

There are also several strengths to this evaluation. A template is presented for recovery focused working in a community psychosis service in a diverse inner-city area that supports discharge back to the family doctor. Available data indicates acceptability to users, and there was some limited evidence suggesting positive changes in key outcomes during service contact. Users and carers had representation in the planning stages from early on, which added valuable perspectives from the point of view of those with lived experience of psychosis. Within the service’s first year, efforts were being made to include the views of those who had used the RET as well as offering paid peer-support worker roles within the RET. Finally, this evaluation suggested an acceptable level of successful discharges back to the family doctor, with a low rate of clients needing further input within a year of their discharge.

Conclusions and next steps

In conclusion, this was a service evaluation of a newly established, recovery focused community psychosis service in Enfield, North London. There was limited evidence suggesting this has been a helpful model for the cohort in this evaluation. Since its beginning in March 2015, it has developed and expanded to support people with non-psychotic mental health problems in secondary care services. Many of the groups now offered have been co-produced and are co-delivered with peer support workers. Future evaluations of new services such as the RET will continue to further our understanding and increase our ability to offer services that are responsive and tailored to the goals of those who avail of them.

Acknowledgments

The authors are sincerely grateful to staff and clients who participated in planning, implementing, using, evaluating, and developing the Recovery and Enablement Track.

Disclosure statement

The authors report no conflict of interest.

References

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. https://doi.org/10.1037/h0095655

Barkham, M., Bewick, B., Mullin, T., Gilbody, S., Connell, J., Cahill, J., Mellor-Clark, J., Evans, C., Richards, D., & Unsworth, G. (2013). The CORE-10: A short measure of psychological distress for routine use in the psychological therapies. *Counselling and Psychotherapy Research*, *13*(1), 3–13. https://doi.org/10.1080/14733145.2012.729069

Bass, M., Dawkin, M., Muncer, S., Vigurs, S., & Bostock, J. (2016). Validation of Warwick-Edinburgh Mental Well-being Scale (WEMWBS) in a population of people using secondary care mental health services. *Journal of Mental Health*, *25* (4), 323–329. https://doi.org/10.3109/09638237.2015.1124401

Butler, L., Johns, L. C., Byrne, M., Joseph, C., O'Donoghue, E., Jolley, S., Morris, E. M., & Oliver, J. E. (2015). Running acceptance and commitment therapy groups for psychosis in community settings. *Journal of Contextual Behavioral Science*, *5*(1), 33–38. https://doi.org/10.1016/j.jcbs.2015.12.001

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. https://doi.org/10.1093/schbul/sbr012

Ebrahim, S., Glascott, A., Mayer, H., & Gair, E. (2018). Recovery colleges; how effective are they? *The Journal of Mental Health Training, Education and Practice*, *13*(4), 209–218. https://doi.org/10.1108/JMHTEP-09-2017-0056

Färdig, R., Lewander, T., Melin, L., Folke, F., & Fredriksson, A. (2011). A randomized controlled trial of the illness management and recovery program for persons with schizophrenia. *Psychiatric Services*, *62*(6), 606–612. https://doi.org/10.1176/ps.62.6.pss6206_0606

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*, *199*(6), 445–452. https://doi.org/10.1192/bjp.bp.110.083733

Manly, C. A., & Wells, R. S. (2014). Reporting the use of multiple imputation for missing data in higher education research. *Research in Higher Education*, *56*, 397–409. https://doi.org/10.1007/s11162-014-9344-9

Mental Health Taskforce. (2016). *The five-year forward view for mental health*. Mental Health Taskforce. Retrieved October, 2019, from https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

Shepherd, G., Boardman, J., Rinaldi, M., & Roberts, G. (2014). *Supporting recovery in mental health services: Quality and outcomes*. Centre for Mental Health and Mental Health Network, NHS Confederation. Retrieved June 13, 2018, from: https://www.centreformentalhealth.org.uk/Handlers/Download.ashx?IDMF=82123340-ed9a-48da-8012-afe66e2614ef

Shepherd, G., Boardman, J., & Slade, M. (2008). *Making recovery a reality*. Sainsbury Centre for Mental Health.

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*, *13*(1), 12–20. https://doi.org/10.1002/wps.20084

Tennant, R., Hiller, L., Fishwick, R., Platt, S., Joseph, S., Weich, S., Parkinson, J., Secker, J., & Stewart-Brown, S. (2007). The Warwick-Edinburgh Mental Wellbeing Scale: (WEMWBS): Development and UK validation. *Health and Quality of Life Outcomes*, *5*(1), 1477. https://doi.org/10.1186/1477-7525-5-63

Triangle Consulting Ltd., & the Mental Health Providers Forum. (2008). *The recovery star*. Retrieved November, 2015, from http://recoverystar.mhpf.org.uk/