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Summary

Personal recovery as an approach to psychiatric rehabilitation is attracting growing attention in many health systems. It emphasises attainment of personal goals, meaning and control in life, rather than symptom alleviation. We examine what economic evidence there is in relation to a set of interventions that could be seen to be consistent with a recovery-focused approach. These include peer support, self-management, supported employment, welfare and debt advice, joint crisis plans and advance directives, supported housing, physical health promotion, personal budgets, anti-stigma campaigns and recovery colleges. For some interventions we could find no economic evidence, and for some others it was methodologically weak, but the interventions for which we could find evidence generally did not appear to increase costs, and many represented cost-effective uses of resources.

Recovery: economic questions

One approach to psychiatric or psychosocial rehabilitation now gaining a lot of traction in many mental health systems is built around the aim of recovery. This is not recovery in the clinical sense of symptom alleviation or even cure, but has a much broader, personal interpretation. It is often associated with a seminal piece by William Anthony (1, p.527):

> Recovery is described 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.
>
> Recovery from mental illness involves much more than recovery from the illness itself. People with mental illness may have to recover from the stigma they have incorporated into their very being; from the iatrogenic effects of treatment settings; from lack of recent opportunities for self-determination; from the negative side effects of unemployment; and from crushed dreams. Recovery is often a complex, time-consuming process.

Personal recovery as an objective and set of principles is embraced in some national mental health policies. For example, the top priority in the English Government's 2014 policy statement was 'High quality mental health services with an emphasis on recovery should be commissioned in all areas' (2). Operationalising recovery principles can take many forms, but the question will always arise – as it should do in *every* area of policy or practice – whether recovery makes economic sense.

Making economic sense?

The core *clinical question* when considering whether an intervention warrants support is whether it reduces symptoms or improves functioning. The core *recovery question* could be the degree to which personally defined goals have been achieved, whether in terms of objective indicators of social roles or subjective indicators of personal goals (3). But because resources are always scarce, decision-makers must think carefully about how to use them, and this gives rise – in either case – to the accompanying *economic question*: are the resources needed to deliver an intervention justified by these clinical or recovery-focused outcomes?

Decision-makers could employ many criteria in making decisions; economic evaluation provides evidence in relation to the *efficiency* criterion: how to get maximum health benefits from available resources. An intervention does not need to be cost-saving to be efficient; it could be more expensive than the alternative with which it is compared, but the additional effectiveness must be sufficient to make the higher cost worth paying.

Recovery: emerging economic evidence

There is no fixed set of actions constituting a recovery approach, nor should there be given that the fundamental premise is to respond to evolving *personal* preferences and changing *individual* needs. However, some interventions can be seen as broadly consistent with the approach. We briefly describe the economic evidence on these approaches, focusing particularly if not exclusively on England. Some of our evidence comes from work on recovery in psychosis undertaken with colleagues (4).

Peer support covers a spectrum of ways in which people receive help, support and sometimes services from others with lived experience of mental illness, including informal contacts between peers to more complex organised group-based activities and social media. Peer support embodies mutuality and reciprocity, and builds on social capital. Despite interest in the approach, there is currently little economic evidence. An uncontrolled study of 260 community-dwelling adults receiving peer-led self-management found significant improvements in wellbeing and costs that decreased a little over a year (5). Another UK study found that peer support during the transition from hospital to home could increase hope, reduce loneliness, improve quality of life and show cost-effectiveness compared to usual aftercare (6). Neither study is especially strong from a methodological standpoint.

Self-management – improving one's ability to manage symptoms and treatment – is clearly integral to a recovery approach. Components of programmes that train people in self-management could include psycho-education, medication management, setting individual recovery goals and developing life skills. Self-management can reduce relapse, prevent readmissions and improve medication adherence, but again there is little economic evidence (7).

Employment is core to recovery for many people with mental health issues – it not only has economic value but confers social benefits such as social networks, status and self-esteem – yet so often they face huge disadvantages in gaining and retaining employment (8), especially during macroeconomic 'crises' (9). There is now plenty of evidence on ***supported employment***, the best known model for which is Individual Placement and Support (IPS) which helps individuals gain competitive employment as quickly as possible and provides ongoing training and support from employment specialists. IPS has been shown to be effective in many countries (10), and a six-city European study demonstrated that it is strongly cost-effective compared to traditional vocational support in many

studies (11). A risk is that IPS services may not be implemented as intended; employing IPS trainers to work with mental health professionals and service users can help.

Paid employment may not be achievable for everyone: some people may not feel they want it, and some may not be able to attain it. Having an appropriate economic 'safety net' is essential in those circumstances, yet many people with mental health issues fail to get the state support to which they are entitled (12). ***Welfare advice*** can increase uptake and reduce costs by shortening inpatient stays, preventing homelessness and preventing relapse (13). ***Debt advice*** services can also be both effective and cost-effective (14, 15).

Individuals experiencing crises, for example as a result of symptom exacerbation in schizophrenia, often have unwanted and lengthy hospitalisation. The way that a health system responds varies from country to country, but ***joint crisis plans and advance directives*** have been suggested. They empower people at risk of compulsory admission, giving them an opportunity to specify in advance their preferences for treatments, for example (16). Although attracting growing interest, we could find no economic evidence about such approaches.

Homelessness is a risk for some people with severe mental health problems, and ***supported housing*** tries to help individuals with complex needs to live independently in the community. If it is well planned and delivered, and of decent quality, supported housing can prevent a damaging spiral of hospitalisation and homelessness, use of emergency services and criminal justice contacts (17, 18). Our own simple economic modelling found that dispersed independent living, when examined in an English context, was more cost-effective than congregate housing (4).

People with enduring mental health problems are at high risk of physical morbidity and premature mortality, in part linked to poor health behaviours such as high rates of smoking, low rates of exercise and poor diet (19). Some medications exacerbate some of these problems through weight-gain and metabolic complications (4). Consequently, ***physical health promotion*** is another important aspect of recovery, with supportive economic evidence for smoking cessation and weight management programmes (20).

Central to government policy in social care in the UK for some years, and more recently also in health care, is the aim of 'personalisation': to give service users more direct choice over how their needs are met. ***Personal budgets*** are potentially one route to this: individuals take control of the (public) funds that would otherwise have been spent through conventional channels on their treatment and support. Subject to a certain amount of monitoring, these budgets allow them to choose the services or support arrangements which they feel they need and want. A randomised trial of personal *social care* budgets in England concluded that they generated better outcomes than standard care arrangements, and – for the subsample of people with mental health issues - were more cost-effective (21, 22). A quasi-experimental study looked at personal *health* budgets and also found them to be cost-effective (23). Both studies have their limitations, but both provide encouragement that recovery-informed purchasing models – for those individuals willing and able to take control – can have important benefits and are economically viable.

The stigma experienced by many people with mental health issues can affect many aspects of their lives, and can often manifest itself in blatant and harmful discrimination (24). Stigma can limit access to education, employment and housing, can damage social relationships and self-esteem, and can erect barriers in the way of seeking treatment. In these ways it can also be socially costly (25). However, although hard to evaluate, studies of ***anti-stigma campaigns*** in Scotland and England show them to have modest but significant positive impacts on population-level attitudes, to be low cost and potentially to be cost-effective because, among other things, they encourage people to use appropriate services, thus heading off crisis-driven events (26, 27).

Finally, we should mention ***recovery colleges***, which have been established in a few countries, although without yet an evidence base. These colleges 'deliver comprehensive, peer-led education and training programmes within mental health services … providing education as a route to Recovery, not as a form of therapy. Courses are co-devised and co-delivered by people with lived experience of mental illness and by mental health professionals. Their services should be offered to service users, professionals and families alike, with people choosing the courses they would like to attend from a prospectus' (28). An uncontrolled evaluation of one college suggested that a majority of people with mental health issues attending had developed their own recovery plans, were more optimistic about the future, and had become more engaged in employment, education and volunteering (29).

Marshalling the evidence

A recent systematic review and narrative synthesis of descriptions and models of recovery noted that the approach 'has been conceptualised as a vision, a philosophy, a process, an attitude, a life orientation, an outcome and a set of outcomes (30). The authors identified five 'recovery processes that have the most proximal relevance to clinical research and practice… : connectedness; hope and optimism about the future; identity; meaning in life; and empowerment' (p.449), and recommended development and evaluation of interventions that could support these processes. However, few such evaluations were identified in their search (31).

Our approach in this paper – which is not built on a systematic review – has been to identify some interventions (services, strategies or actions) that could be seen as consistent with the personal recovery approach, and then to address the question that any budget-constrained decision-maker is likely to ask: is there an economic case? Our answer to this simple question is perhaps best described as a loose collection of fragments of evidence drawn from a heterogeneous set of studies of variable quality.

The available economic evidence is patchy and sometimes methodologically weak, but insofar as the interventions for which we could find evidence are consistent with a recovery-focused approach, then the overall impression is broadly supportive. Interventions that aim to empower people with mental health issues, helping them to pursue goals which they value as important to them individually, do not appear to increase costs. Indeed, in many cases, they lead to a more cost-effective utilisation of resources. At the same time, there are developments such as recovery colleges that are moving ahead quite rapidly but without yet much evidence on their effectiveness or economic implications.

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