YOUR WAY

An evaluation of a model of community mental health support developed by Together for Mental Wellbeing

Mental Health Foundation

This report is the result of a three-year independent evaluation of the impact of Together for Mental Wellbeing's personalised, community-based mental health services. The project was funded by the Department of Health.

Acknowledgements

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EXECUTIVE SUMMARY

In 2010, Together transformed its Day Centre services into personalised, flexible support services based in the community. This new approach is called Your Way. The Mental Health Foundation conducted a three-year evaluation of Your Way.

The Your Way model has five essential elements:

1. Meaningful personalisation.
2. Open-minded approach and high-quality service.
3. Peer support.
4. Healthy living in the community.
5. Service-user leadership.

People can access support from the service via referrals from Community Mental Health Teams (or in some cases through Supporting People panels), their GP or through self-referral. Those with a personal budget can use this to purchase support from the service.

Methodology

A mixed-methods approach focused on the following aspects of Your Way:

- Increased mental and physical wellbeing.
- Improvements in functional living skills.
- The achievement of self-directed goals.
- A reduction in mental health hospital bed use.
- Improved service-user experiences.

The key outcomes measured were subjective wellbeing and health-promoting lifestyle activity across a 12-month period in 13 of the Your Way sites.

In addition, the evaluation aimed to assess the cost savings provided by Your Way in relation to comparable support delivery, and between service costs pre- and post- transformation to the model.

Semi-structured interviews using schedules based on the five essential elements were conducted by peer researchers with service users in five of the Your Way sites.

Findings

Wellbeing

There were statistically significant increases in wellbeing in the first three months of service use for people who enrolled on the evaluation within a month of accessing support from Your Way.

Lifestyle

There were statistically significant improvements in relation to *social life and relationships, a sense of meaning, dealing with health professionals, and health-promoting lifestyle activity* for people who enrolled on the evaluation within a month of accessing Your Way.

Goals

Goals relating to *physical health and wellbeing* were the most frequently identified across the sample at baseline, and were rated 'very important' for the majority of all participants. The highest proportion of participants who completed baseline data within a month of accessing Your Way achieved their goals at the six-month follow-up time point.

The qualitative interviews identified aspects of Your Way, which service users particularly valued. Your Way created a community and social network that improved resilience. The Your Way staff had an open-minded approach and provided a high-quality service. Service users valued peer support, the experience of self-directed support and the use of incremental goal setting to progress recovery.

The costing comparison exercise was used to examine the differences between the cost of Your Way and the statutory cost of comparable levels of service delivery. This exercise highlighted the challenges of costing voluntary sector services and led to a recommendation regarding strategic action to create a framework for costing voluntary sector services.

Case studies in Wandsworth and Southwark illustrate the findings of this exercise.

In Wandsworth, up until 2009–2010, services consisted of traditional day care. 134 clients were supported annually at a cost of over £700,000. A tiny proportion of these people moved on to positive outcomes (three per annum). Following service transformation, more people are supported each year: 165 at a significantly reduced cost (reduced by more than £538,000 per annum). Crucially, a significant majority of these people moved on to more positive outcomes (101 in the year 2013–2014).

Recommendations

The personalised ethos and innovative approach of Your Way poses a substantial challenge to evaluation. The evaluation's five recommendations reflect the following challenges:

- Consequent variation of Your Way in different sites (in response to local needs, eligibility criteria, community characteristics and funding streams).
- External factors such as the changing commissioning environment and the slow implementation of personal budgets.

1. **Your Way approach:** We recommend that Together continues to learn from the development of this approach both in terms of the operation of the five essential elements and the totality of Your Way using an action research methodology within each site.
2. **Embedding the Your Way model:** We recommend that Together continues to embed the Your Way approach in ways that reflect funding streams and local differences within each site (including differences in service user profiles, staff backgrounds and skills, and the communities in which services are based).
3. **Development of an evaluation approach:** We recommend that Together and other service providers continue to develop evaluation approaches to personalised community mental health provision. For Your Way, this evaluation approach should develop flexibly in order to understand the following: (i) the developmental, 'transformation' and 'embedding' processes; (ii) the longer-term operation with regard to service user leadership and sustainability. Future evaluations should include process and outcome components, and include the perspectives of staff (strategic, service management and front line), peer supporters and service users.
4. **Cost benefit analysis (CBA):** We recommend that the Department of Health invests in the independent development of a CBA approach for innovative voluntary sector provision in mental health. This will require government funding as it is beyond the resource and remit of individual service providers.
5. **Personal budgets:** We recommend that the UK Government, service providers, research and representative organisations review the rollout of personal budgets across the country for people with mental health problems, including people who experience episodic ill health. This review should consider the commissioning and (national and local) policy leadership required to develop innovative self-directed support models and services.

INTRODUCTION

Together for mental wellbeing is a national mental health charity that works alongside people with mental health problems towards leading independent, fulfilling lives. They provide a range of services including housing, advocacy, criminal justice services, and community support. In 2010, Together transformed its Day Centre services into personalised, flexible support services based in the community. It called this model of support Your Way.

An evaluation was commissioned and funded by the Department of Health. This report describes the evaluation conducted and distils the findings and outcomes of Your Way.

Background

The 2012 White Paper *Caring for our future: Reforming care and support* set out a new vision for reforming care and support for older and disabled people, including those with mental health problems (1). The aim was to create a new system that promotes wellbeing and independence to reduce the risk of people reaching crisis point, while at the same time improving their lives.

A personalised approach underpins this policy, which includes people being able to have real choice and control over the care and support they need to achieve their goals. Independence and self-directed support, therefore, are fundamental to this approach (2).

Two years prior to the 2012 White Paper, the London Borough of Wandsworth reviewed the provision of their Day Centres for adults experiencing mental health problems. Commissioners in Wandsworth were keen to incorporate a personalisation approach into this redesign, while delivering significant economic savings.

Around the same time, there were increasing difficulties with implementing the personalisation agenda in mental health. This included the difficulty of deciding which care needs are health and/or social, eligibility issues for fluctuating conditions, the role of care coordinators as gatekeepers, and perceived risks and concerns about the capability of people with mental health needs to always have the insight necessary to design and maintain their own support (3). Individual or personal budgets were seen as an indicator of the success of the personalisation agenda (4).

The Your Way service model was developed within this context. In partnership with commissioners, service users and staff from a Community Mental Health Team in Wandsworth, Together transformed its Day Centre support for adults experiencing mental health problems. The underpinning principle of Your Way is to provide flexible, personalised support that sees individuals defining their own goals and leading their journey to recovery. Your Way staff aim to work alongside carers and other professionals involved in people's care.

The Your Way model was piloted in Wandsworth and subsequently used to transform more than 20 Together community support services across England.

Overview of Your Way

Your Way focuses on working alongside people to achieve the goals they have set themselves, building their resilience and helping them to identify support structures and community resources outside the formal healthcare system. Peer support is a key feature of the service, and individuals have the option of training to become peer supporters themselves.

Your Way uses a 'whole picture' approach to supporting someone via relationships with family, friends and neighbours, as well as professionals and other agencies. Support workers use smartphone and netbook technology to work flexibly and adapt their approach to meet individual service-user needs.

The service is underpinned by five essential elements:

1. Meaningful personalisation.
2. Open-minded approach and high-quality service.
3. Peer support.
4. Healthy living in the community.
5. Service-user leadership.

People can access support from the service via referrals from Community Mental Health Teams (or in some cases through Supporting People panels), their GP, or through self-referral. Those with a personal budget can use this to purchase support from the service.

EVALUATION

In March 2012, an independent evaluation of Your Way was commissioned by Together using a funding award from the Department of Health. The Mental Health Foundation undertook a three-year evaluation to assess the impact and benefits of Your Way across 13 sites in England.

Aims and objectives

The evaluation aimed to establish the effectiveness of Your Way as an intervention for people with mental health problems and whether the support provided led to:

- Increased mental and physical wellbeing.
- Improvements in functional living skills.
- The achievement of self-directed goals.
- A reduction in mental health hospital bed use.
- Improved service-user experiences.

The key outcomes measured were subjective wellbeing and health-promoting lifestyle activity across a 12-month period.

In addition, the evaluation aimed to assess the cost savings provided by Your Way in relation to comparable support delivery, and between service costs pre- and post-transformation to the model.

Methods

Evaluation design

The evaluation used a mixed-methods design to collect both quantitative and qualitative data. The quantitative component used a longitudinal exploration to assess the impact of personalised, community-based services on recovery from mental health problems on each of the outcomes of interest over time.

Quantitative data were collected using a series of standardised questionnaires given to participants at four time points (T1–T4):

– T1: Baseline and first access to Your Way.
– T2: Three months after baseline or first access.
– T3: Six months after baseline or first access.
– T4: 12 months after baseline or first access.

Questionnaires

The following questionnaires were used to collect data on participants' mental wellbeing, health-promoting lifestyle activity, goal attainment, and hospital bed use:

Baseline demographic characteristics and mental health status: Participants were asked to complete a questionnaire, designed by the evaluation team, about their demographic details, mental health status and previous service use (see Appendix 1).

Wellbeing: Mental wellbeing was assessed using the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS), a self-completed measure of mental wellbeing developed by researchers at the University of Warwick and Edinburgh (5). The scale comprises 14 items, answered using a five-point scale. The minimum score is 14 and the maximum is 70, with higher scores corresponding to higher mental wellbeing (see Appendix 1).

Health-Promoting Lifestyle Profile II (HPLP II): The HPLP II was designed to measure health-promoting lifestyle activity, and is based on a health promotion model (6). The US-developed HPLP II was adapted by MHF for use in the UK (see Appendix 1). The adapted HPLP II consisted of 42 items grouped into six subscales: *general health, exercise, food, social life, dealing with health professionals and finding meaning*. Response options for each item are on a four-point scale (*never; sometimes; often; always*). A mean score is computed for each subscale and for overall *lifestyle*.

Goal Attainment Scaling: Progress in goal achievement was assessed with Goal Attainment Scaling (GAS) (7). At baseline (T1), participants were asked to identify three goals to work towards in the following three-month period. They were then asked to rate these goals in terms of their perceived importance (*not at all; a little; moderately; very*), and difficulty (*not at all; a little; moderately; very*). These goals were then revisited at the following time point to assess whether or not the goals had been achieved, and to what degree. This procedure was then repeated at T2 and T3, before measuring a final rating of goal attainment at T4 (see Appendix 1).

Hospital bed use: Data on hospital bed use was obtained by self-report. At T1 and T4, participants were asked the number and duration of any inpatient hospital admissions in the previous year.

In the first year of the evaluation, questionnaire data was completed autonomously by Your Way service users, with resources in the local areas used to organise and support the process. At each of the four time points (T1–T4), participants were given the option to self-complete hard copies of the questionnaires, or to complete them online using Survey Monkey. In the second year of the evaluation, a Research Assistant was employed to coordinate the data collection across the participating sites. This action served to maintain greater levels of engagement, and to address quality issues, such as missing data. A prize draw incentive was also introduced at baseline and each follow-up stage for all participants.

Site recruitment

In the first year of the evaluation, eight Your Way pathfinder sites were selected to participate in the evaluation. In the following year, the number of sites was expanded from eight to 19, in order to maximise the pool of participants. A total of 16 Your Way sites returned data as part of the evaluation. However, the number of sites was reduced to 13 in the final analysis; one Your Way site closed in April 2014 and two sites were excluded as they had only one participant.

Recruitment and number of participants

The evaluation was designed to focus on people who were new to the service. However, when services began their transformation to Your Way, existing service users were classed as 'new clients'. All users of Your Way at each of the 16 evaluation sites were offered the opportunity to participate in the evaluation. This included people of all ages from 16 years and above, with no upper age limit. Your Way staff provided users of the service with consent forms and information sheets about the study, and service users were given the choice to 'opt in' to the evaluation.

Originally, it was planned to recruit 600 people to the evaluation, with data collected at each of the four time points described above. However, recruiting this number of participants proved difficult (see Limitations section).

Costing comparison

A costing comparison exercise was used to examine the differences between the cost of Your Way and the statutory cost of comparable levels of service delivery.

Qualitative data collection and sites

It was planned that 30 participants would take part in in-depth qualitative interviews conducted by peer researchers at baseline and again after 12 months to gain more in-depth information about the service.

Two semi-structured interview schedules were developed to capture qualitative data from participants about their experience of using Your Way. Open-ended questions were derived from the five key principles underlying the Your Way model – *user leadership and equal partnership; meaningful personalisation; open-minded approach and high-quality service; peer support; and healthy living in the community* – and piloted with an existing user of Together's services.

Peer researchers were selected through an open recruitment process advertised through Together's Service User Involvement Directorate and via a network of people who used or had used Your Way. Interview training was delivered by the Your Way Development Manager, using materials provided by the Mental Health Foundation.

Between September 2013 and October 2014, peer researchers conducted semi-structured

baseline and follow-up interviews with participants using Your Way at five of the 13 sites included in the evaluation (South Warwickshire, Hastings, Reading, Wandsworth and Southwark).

Ethical issues

Written informed consent was obtained from all participants and separate consent was obtained for those participants taking part in qualitative interviews. To ensure participant confidentiality, and the independence of the evaluation, Your Way staff were not directly involved in the data collection. All participants were assigned an individual participant code so as to protect their anonymity. All data were stored in accordance with the Data Protection Act 1998. No formal ethical approval was required as the project was a service evaluation.

Data analyses

Data from hard-copy questionnaires were entered and stored at Together's central London office. These were then collated by the Mental Health Foundation and analysed using the Statistical Package for Social Sciences (SPSS) Version 21.0. Descriptive statistics were used to perform frequencies and to calculate total and mean/median scores for relevant outcomes (e.g. wellbeing).

Crosstab analyses were carried out to identify patterns in participants' goal setting and goal attainment over the course of the evaluation. Crosstab analyses of participants' goal achievement ratings were also analysed.

Participants missing more than three items of data on the wellbeing measure were excluded from the analysis. Similarly, participants missing more than eight items of data on the health-promoting lifestyle questionnaire were excluded from the analysis.

Interpretative statistics were used to analyse trends in the data, such as changes in wellbeing and health-promoting lifestyle activity scores from T1 to T2, T3 and T4. Wilcoxon signed-rank tests were used to ascertain the statistical significance of any differences detected.

Analysis focused on participants who completed data for more than one time point; participants who did not complete data at baseline were excluded from the analysis.

Costings were quantified by comparing the full service costs prior to the introduction of the Your Way model, with the costs of the Your Way model at stable state. Transition costs were also tracked. Measures of cost savings included comparison of costs per service user, and comparison of Your Way with other services designed to achieve similar levels of service.

Qualitative data were analysed thematically and in relation to Your Way's five essential elements listed above and to explore which aspects of the model were most meaningful to them. Themes were noted as they arose from the data, many of which were related to the framework provided in the interview schedule. Transcripts were coded in accordance with this framework. The coding framework was subsequently refined, with similar themes merged and sub-themes created where appropriate.

Evaluation sites

Table 1 provides details of the evaluation site characteristics at the point these were collected during October 2014. These include a summary of provision and funding method, availability of peer support, staffing structure, and the number of people supported each month.

Name of service (date service transformed to Your Way model)	Summary/current provision	Building- based	Community-based	Peer support	Number of people supported each month	Funding method	Staffing structure
Wandsworth (April 2011)	Personalised day support, includes 12 weeks community-based support of six interventions and longer-term support for personal budget holders who may be supported to apply for a personal budget for longer-term support. Two user-led organisations subcontracted to provide open access drop-ins for anyone with a mental health problem. Re-ablement provides practical support based on individuals' personal goals. This includes signposting people to services or support and helping them find ways to stay well.		X	X	80 (50 long-term clients, 20–30 short-term clients)	Local Clinical Commissioning Group (CCG)/ personal budgets	0.5 Project Coordinator/2.5 FT Your Way Workers/6–10 Peer Support Volunteers organising community activities and offering 1:1 support
Barnsley (April 2011)	Provides 1:1 support for people funded through personal budgets or self-funded. The service is complemented by a befriending service, a court liaison service and a GP Navigators service. Support is provided in community locations and people's homes. There is no physical hub but drop-in facilities are provided twice a week.		X		Personal budgets: 46 Befriending: 19 GP Navigators: 26 Court Liaison Service: 3	Personal budgets/ self-funding/spot funding	
Reading (April 2011)	Support provided from a central hub includes: drop-in facilities, service user-led activities, and a paid and volunteer support model. Accredited peer support training has been available since 2004. Group activities, 1:1 sessions (by staff and peer supporters), and support for accessing community facilities and attending appointments/meetings are all available. The service also includes regular outreach in local hospitals and health groups.	X	X	X	135	Local authority grant funding/ Local Clinical Commissioning Group (CCG)	1 FT Project Coordinator/1 FT Peer Volunteer Coordinator/2 Senior Support Workers/1 FT Support Worker/10 PT Peer Support Workers
South Warwickshire (June 2011)	The service has three components: Floating Support Services, Supported Accommodation and people receiving personal budgets. All support is provided in people's homes and in the community. Supporting People funded support is limited to two years. The service won a bid from Stratford Town Trust for a befriending service aimed at tackling loneliness and isolation in the Stratford Town area. Support focuses on homelessness, debt, rent arrears, healthy living, social isolation and substance misuse, etc.		X	X	70 people for 3.75 hours/week through the Floating Support Service 16 Supported Accommodation	Local authority Supporting People/ individual budgets/ self-funders	1 Project Coordinator/1 Service Leader/7 FT Your Way Workers/2 PT Your Way Workers
North Warwickshire (June 2011)	The service has three components: Floating Support Services, Supported Accommodation and people in receipt of direct payments. All support is provided in the community. Supporting People funded support is limited to two years. Support focuses on topics such as homelessness, debt, rent arrears, healthy living, dealing with correspondence, social isolation, agoraphobia, substance misuse, etc. The service supported a group who became the Rugby Service User Activity Group in 2012. The service user-led group aims to reduce isolation with regular social meetings and trips away. The service refers into the group and supports new people to their first few meetings.		X	X	Contracted to support 55 people a week through the block contract Currently, 18 people are funded through personal budgets	Local authority Supporting People/ individual budgets/ self-funders	1 Project Coordinator/2 Service Leaders/6 FT Your Way Workers/4 Peer Supporters

Name of service (date service transformed to Your Way model)	Summary/current provision	Building- based	Community-based	Peer support	Number of people supported each month	Funding method	Staffing structure
Swale (April 2012)	Community-based support across two sites (Sheppey and Sittingbourne) with a focus on social inclusion. Includes service user-led activities to prevent social isolation. Service users lead on two drop-in sessions p/w at an internet café. No building-based service, though some space shared with a local resource centre. Has a focus on practical groups (e.g. gardening, physical exercise). One-to-one support is available for people in crisis/those who require practical interventions.		X		177	Local authority funding (block contract)	1 FT Project Coordinator/4 PT Community Support Workers/3 Volunteers
Southwark (April 2012)	No physical location with all support delivered in community locations around the borough. Peer support and group activities provide support focusing on social inclusion. All support is provided by a blended offering of Your Way Workers and Peer Supporters providing 1:1 support in community locations. Peer Supporters and volunteers also provide support to group activities that take place in the community. Weekly drop-in sessions are available.		X	X	70	Local Clinical Commissioning Group, with personal budgets for long-term need	PT Project Coordinator/ PT Peer Support Coordinator/2 FT Your Way Workers/5–10 Peer Support Workers
Shropshire (October 2012)	1:1 community support in rural community settings. Referrals are from the Supporting People panel but some people are now self-funding. Staff provide personalised support within the Supporting People contract, usually for housing-related support. Support is provided in the community and client's homes. An office building hosts a weekly drop-in service. The staffing team attends a food bank drop-in and provides a regular computing initiative.		X	X	72 (6 of whom are self-funding)	Local authority Supporting People	1 FT Project Co-coordinator/1 PT Service Leader/1.5 Your Way Workers/3 Relief Workers/1 Peer Supporter
Bexhill (October 2012)	Daily drop-in sessions from two local hubs. 1:1 support is in the centre and community settings as per client need. Service user-led activities are held in the centre, including a service user-run kitchen. Outcome-based support plans are used and personalisation training was delivered in March 2013. Peer support training was provided in February/March 2014 and two Peer Supporters now provide both 1:1 and group sessions.	X	X	X	120	Local authority block contract	1 FT Project Coordinator (0.5 between Hastings/ Bexhill)/2 FT Team Leaders (1 at site)/5 FT Your Way Workers over both projects

Name of service (date service transformed to Your Way model)	Summary/current provision	Building- based	Community-based	Peer support	Number of people supported each month	Funding method	Staffing structure
Bexhill (October 2012)	Daily drop-in sessions from two local hubs. 1:1 support is in the centre and community settings as per client need. Service user-led activities are held in the centre, including a service user-run kitchen. Outcome-based support plans are used and personalisation training was delivered in March 2013. Peer support training was provided in February/March 2014 and two Peer Supporters now provide both 1:1 and group sessions.	X	X	X	120	Local authority block contract	1 FT Project Coordinator (0.5 between Hastings/ Bexhill)/2 FT Team Leaders (1 at site)/5 FT Your Way Workers over both projects
Hastings (October 2012)	As Bexhill.	X	X	X	120	Local authority block contract	Shared with Bexhill
Lewes (October 2012)	Two hubs provide 1:1 support and group activities. Both offer daily drop-in sessions and 1:1 support in the building and the community. Activities in the hubs are mainly service user led. Support is largely focused on social interaction, emotional support and problems such as social isolation. The centre offers several activities including a weekly bread club, mindfulness sessions, art groups, reading groups, a current affairs group, and healthy meals for £3 per head.	X	X	X	Lewes: 62 Newhaven: 112	Local authority block contract	1 FT Project Coordinator both hubs/3 FT and 3 PT Your Way Workers across both hubs
Newhaven (October 2012)	As Lewes above, but Newhaven tends to provide more debts and benefits support.	X	X	X	See above	Local authority block contract	Shared with Lewes
Rochdale (April 2013)	Service is predominantly funded through Supporting People contract. Complementing this funding is a block social inclusion grant fund and also a grant-funded befriending service. The service provides a pathway to better community connections, increased independence and volunteering opportunities. The service can also support people via spot purchase.		X	X	Supporting People: 36 Social Inclusion: 24 Spot purchases: 10	Local authority Supporting People/ Social Inclusion Fund/Spot purchase via local authority	1 FT Project Coordinator/1 Senior Support Worker/4.5 FT Community Support Workers/1 FT Housing Officer

Table 1: Characteristics of the 13 sites included in the evaluation

RESULTS

Baseline characteristics of the sample

In the final analysis, the number of sites was reduced to 13; two of the original 16 evaluation sites were excluded as they had only one participant and one site closed in April 2014.

Across the 13 sites, a total of 343 Your Way users consented to take part in the evaluation. However, only participants with recorded start dates at the service were included in the evaluation; these were available for 297 participants. Figure 1 shows the number of participants by site. Just under half of participants were from North and South Warwickshire, Reading and Hastings (47%, n=141/297).

Access to Your Way and baseline assessment

Just under a third of participants (32%, n=95/297) were existing users of the service (for example, the local Day Centre) before its transformation to Your Way; 68% (n=202/297) had begun accessing the service post-transformation to Your Way.

The length of time that participants had been accessing Your Way before completing baseline data varied. For the purpose of analysis, participants were categorised into three groups based on when they completed baseline data and when they started accessing Your Way (see Table 2). The proportion of participants was similar for each group.

Demographic characteristics

A total of 288 participants supplied their demographic data. Of these, 51% (n=147) were male and 49% (n=141) were female. The average age overall was 47.8 years (ranging from 17 to 84 years) and was similar for men (47.6 years) and women (48.1 years). The largest proportion of participants were from a white British ethnic background (89%, n=254).

Just under half (47%, n=129/275) of participants reported that they had a physical disability. Many participants were unemployed (91%, n=256,) and just under a quarter (23%, n=59) were volunteering at the time of baseline data collection.

Barnsley	7%
Bexhill	9%
Hastings	12%
Lewes	6%
Newhaven	3%
North Warwickshire	13%
Reading	10%
Rochdale	5%
Shropshire	3%
South Warwickshire	13%
Southwark	7%
Swale	6%
Wandsworth	6%

Figure 1: Proportion (%) of participants by Your Way site

	Length of service use before completing baseline data	Frequency (%)
Group 1	1 month or less	95 (32%)
Group 2	2–12 months	108 (36%)
Group 3	12+ months	94 (32%)

Table 2: Length of service use before completing baseline data

Reported diagnosis

Figure 2 shows the main diagnostic categories reported by all participants. Depressive disorders were the most common, followed by schizophrenia and other psychotic disorders. Only 5% (n=13) had not received a diagnosis. Most (92%, n=210/228) accepted their psychiatric diagnosis.

Of the 39 participants reporting comorbid/other diagnoses, these were mostly mixed anxiety/depression (n=24).

The average age participants became aware of their condition was 27.1 years and the average age of diagnosis was 31.3 years.

According to the three groups described above, the greatest proportion of participants in Groups 1 and 2 reported a main diagnosis of depressive disorders (28%, n=21 and 33%, n=29 respectively). In Group 3, the largest proportion of participants (34%, n=28) reported a main diagnosis of schizophrenia or other psychotic disorders.

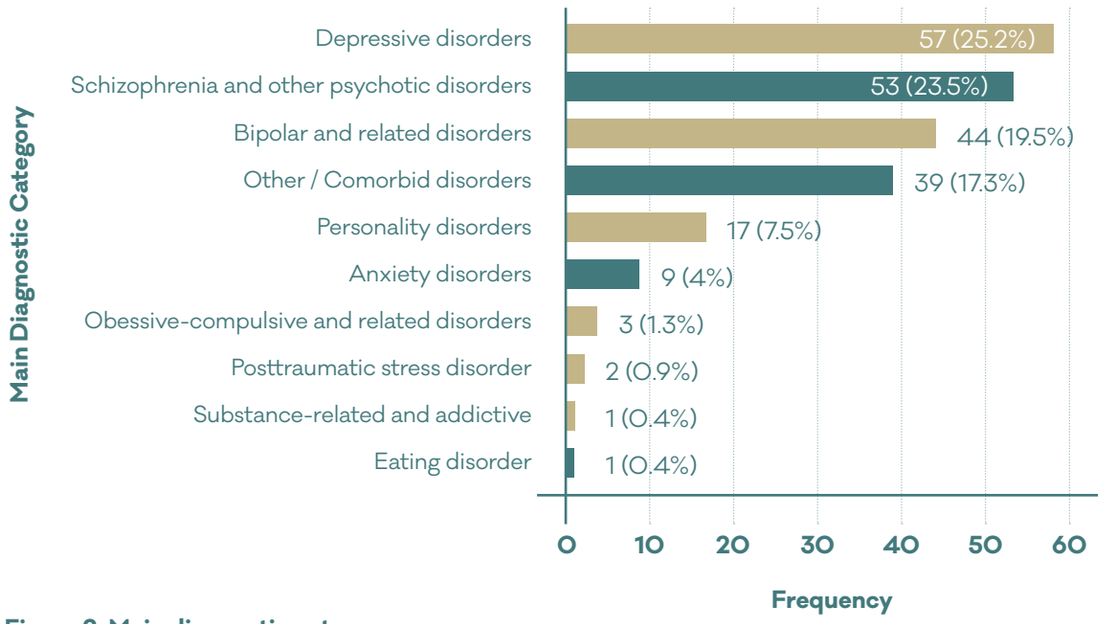


Figure 2: Main diagnostic category

The majority of participants (95%, n=238/251) reported taking some form of psychotropic medication.

Suicide attempts

Over half (62%, n=171/274) had attempted suicide in the past. The number of attempts ranged from 1–80, with an average of 4.6.

Contact with mental health services

Many people were in contact with health and social services. The frequency of contact with health and social care professionals is shown in Table 3.

Key outcomes

The key outcomes measured as part of the evaluation were subjective wellbeing and health-promoting lifestyle activity across a 12-month period. The number of participants responding to the wellbeing, health-promoting lifestyle and goal attainment questionnaires varied considerably across the four time points (more details can be found in Appendix 1). Responses declined at six months (T3) and 12 months (T4) by less than a half compared to baseline responses. Despite this outcome, scores are presented across each time point.

Wellbeing

Changes in WEMWBS score following access to Your Way

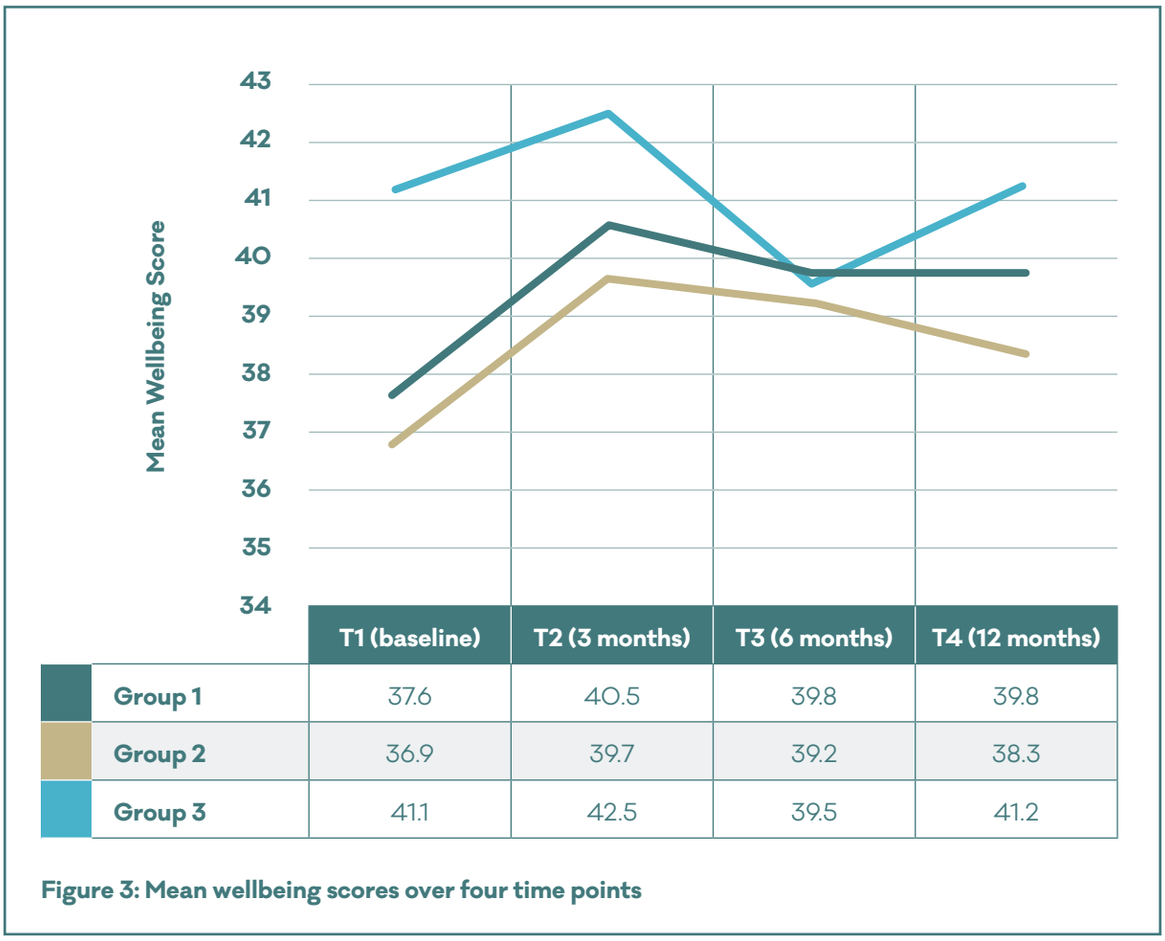
WEMWBS is a 14-item scale answered using a five-point scale. The minimum score is 14 and the maximum is 70, with higher scores corresponding to higher mental wellbeing. Figure 3 shows the mean wellbeing scores across T1, T2, T3 and T4 data by group, where available (full scores can be found in Appendix 1). Wellbeing scores when compared to those at baseline increased for all three groups, peaking at three months (T2) and dropping after this time. This decline is more notable for Group 3 at six months (T3), which then rises again at 12 months (T4).

Increases in the mean wellbeing score from 37.7 at baseline (T1) to 40.5 at three months (T2) were found to be statistically significant for the 60 service users who completed baseline data within a month of accessing Your Way (Group 1: z=-2.441, p=.015). Although wellbeing scores at six (T3) and 12 months (T4) were higher than the baseline score, these differences were not significant. A total of 16 participants in Group 1 completed the wellbeing questionnaire at T1 and T4, showing an increase in mean scores from 37 at T1 to 39.8 at T4, although this difference was not statistically significant.

The mean WEMWBS score for the 67 participants in Group 2 who completed WEMWBS at both T1 and T2 increased from 36.6 at T1 to 39.7 at T2; a non-parametric test indicates that that increase was significant (z=-2.819, p=.005). Similarly to Group 1, these mean scores were higher between six and 12 months (T3 and T4) compared to the baseline score, but these increases were not statistically significant. It is possible that the reduced sample size at follow-up time points (particularly T3 and T4) may have contributed to the non-significant result.

	Psychiatrist	Community Practice Nurse (CPN)	Social Worker
Regularly	n=103 (42%)	n=67(31%)	n=60 (27%)
When I need to be	n=91 (37%)	n=46 (21%)	n=51 (23%)
I choose not to be	n=18 (7%)	n=15(7%)	n=16 (7%)
Never been referred	n=36 (15%)	n=89 (41%)	n=92 (42%)

Table 3: Contact with health and social care professionals



	T1 (baseline)	T2 (3 months)	T3 (6 months)	T4 (12 months)
Group 1	37.6	40.5	39.8	39.8
Group 2	36.9	39.7	39.2	38.3
Group 3	41.1	42.5	39.5	41.2

Figure 3: Mean wellbeing scores over four time points

Unlike the other groups, the increase in the mean wellbeing score for Group 3 from baseline to three months (T1 to T2) was not statistically significant, although the mean wellbeing score at baseline was higher (see Figure 3). These mean scores dip slightly at six months (T3) (39.5), but return to baseline levels at 12 months (T4) (41.2).

Health-promoting lifestyle activity

Changes in Lifestyle Profile II score following access to Your Way

The modified HPLP II is a 42-item scale answered using a four-point scale, composed of six subscales (general health, exercise, food, social life, dealing with health professionals, and finding meaning). The overall score (health-promoting lifestyle) is a mean of all answers; the six subscale scores are a mean of the responses to the subscale items. The minimum score is 1 and the maximum is 4, with higher scores corresponding to higher health-promoting lifestyle.

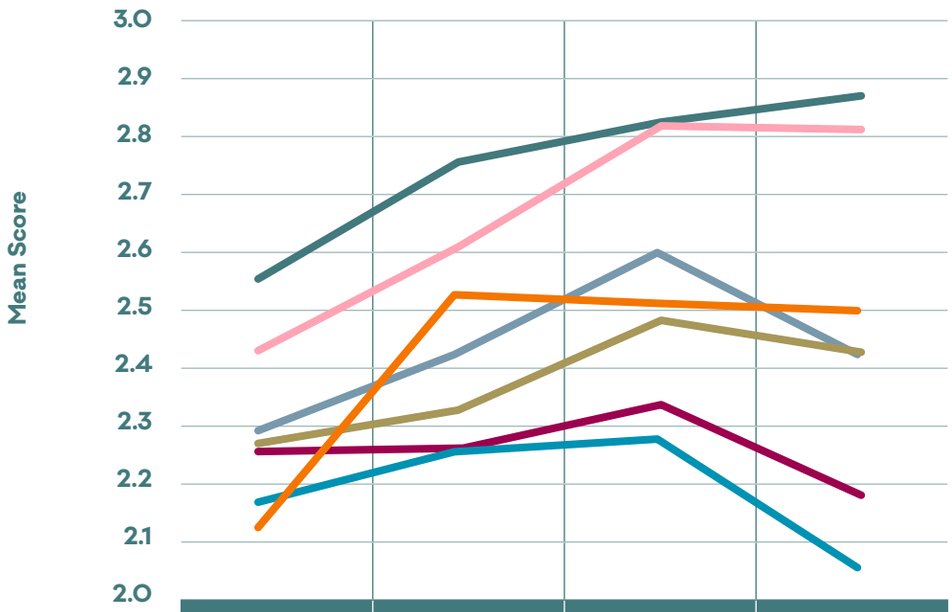
Mean scores for health-promoting lifestyle activity show a similar pattern to wellbeing scores in relation to the different groups examined. Figure 4 shows the descriptive scores for the HPLP II for Group 1 at baseline (T1), three months (T2), six months (T3) and 12 months (T4).

Statistically significant increases across the different time points were found for service users in Group 1 (participants who completed baseline data within a month of first accessing Your Way) in relation to improved *social life, finding meaning, dealing with health professionals*

and lifestyle (see Appendix 1 for inferential statistics). Statistically significant increases in social life and finding meaning were found across each of the four time points, suggesting sustained improvements in these areas which did not occur by chance.

Statistically significant improvements in *general health* scores were found for participants in Group 2 going from a mean of 2.10 at baseline to 2.29 at three months. Mean scores for *exercise* also improved significantly for 114 participants, as did scores for *diet* at three months.

There were no statistically significant differences found for participants in Group 3 (participants who had accessed Your Way for 12+ months before completing baseline data). Again, scores for this group remained broadly similar throughout the different time points, suggesting maintenance of aggregate lifestyle factors over time rather than overall improvements.



	T1 (baseline)	T2 (3 months)	T3 (6 months)	T4 (12 months)
General Health	2.18	2.26	2.29	2.06
Exercise	2.27	2.26	2.34	2.19
Food	2.29	2.33	2.49	2.44
Social Life	2.43	2.61	2.83	2.81
Health Professionals	2.56	2.75	2.83	2.88
Finding Meaning	2.12	2.52	2.51	2.5
Lifestyle	2.3	2.43	2.6	2.44

Figure 4: Mean HPLP II scores for Group 1

Goal identification and attainment

Participants were asked to indicate three equal-weighted goals to work towards over the following months. They were then asked to rate these goals in terms of their importance and perceived difficulty. Participants then revisited these goals at the following time point and rated whether or not they had been achieved, and, if so, to what degree. Here we report the three main goals set by participants and their achievement over time by each of the three groups.

The goals identified were grouped into eight broad categories:[1]

1. Physical health and wellbeing.
2. Mental health, medication and service use.
3. Social support, family and community.
4. Creative interests and hobbies.
5. Employment, education and volunteering.
6. Housing, legal and financial.
7. Life skills/independence.
8. Personal development/sense of self.

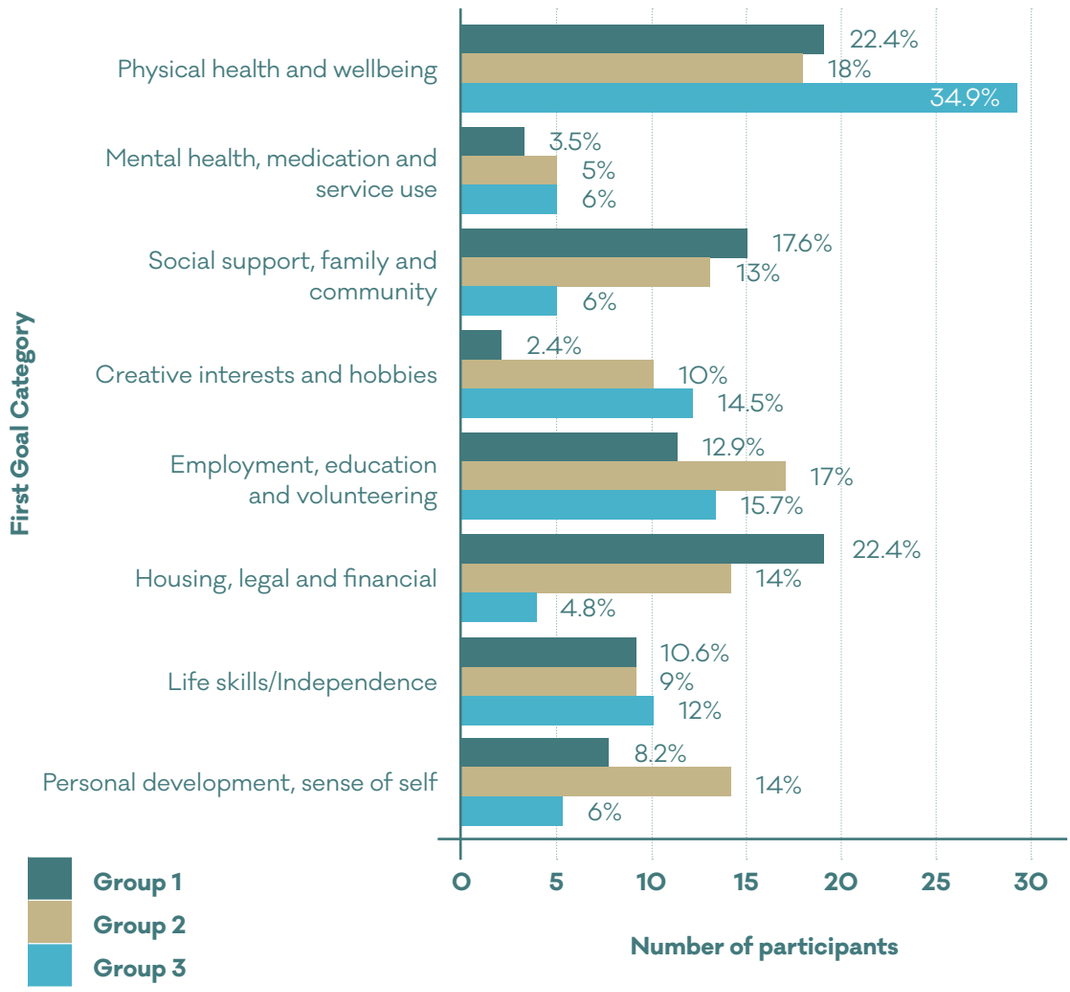


Figure 5: Identified first goals by participant groups

1. A detailed description of goal categories is available in Appendix 2.

Identifying goals

Physical health and wellbeing was the most frequently identified first goal across all three groups at baseline (Group 1: n=19/66, Group 2: n=18/66, Group 3: n=29/66). Housing, legal and financial issues (22.4%, n=19) and social support, family and community (17.6%, n=15) were common first goals identified by Group 1. For Group 2 this related to employment, education and volunteering (17%, n=17). Few selected mental health, medication and service use as a primary goal.

Between 72% and 80% of all participants rated their first goal as 'very important', but roughly half of these considered this very difficult to attain.

Common second goals for Group 1 included social support, family and community (18.8%, n=15), closely followed by employment, education and volunteering (16.3%, n=13) and physical health and wellbeing (15%, n=12). For Groups 2 and 3, physical health and wellbeing were important (Group 2: 22.6%, n=21; Group 3: 23.5%, n=19).

The majority of participants in all three groups rated their second goal as 'very important' (Group 1: 71.3%, n=57; Group 2: 70.7%, n=65; Group 3: 64.8%, n=54). However, up to half of all participants rated their second goal very difficult or moderately difficult to achieve.

Third goals were more varied between groups. Participants from Groups 1 and 2 were likely to identify goals concerning social support, family and community (18.6%, n=13; 23.3%, n=20), while Group 3 identified creative interests and hobbies (23%, n=17).

A high proportion of participants from all groups (between 69% and 82%) rated these third goals as very important. The majority of participants from all three groups rated their third goal as being very difficult to achieve (Group 1: 58%, n=40; Group 2: 57.1%, n=48; 41.1%, n=30).

Achieving goals at three months

Around half of all participants had achieved their first goal (Group 1: 46%, n=23; Group 2: 45.8%, n=27: Group 3: 56%, n=28), with 81 reporting that this was not achieved. For some (n=17), achieving this first goal was better than expected, but 50 participants felt this was 'worse than before', particularly those in Group 2 (73% or 25).

Across the three groups, participants were marginally more likely to report having achieved

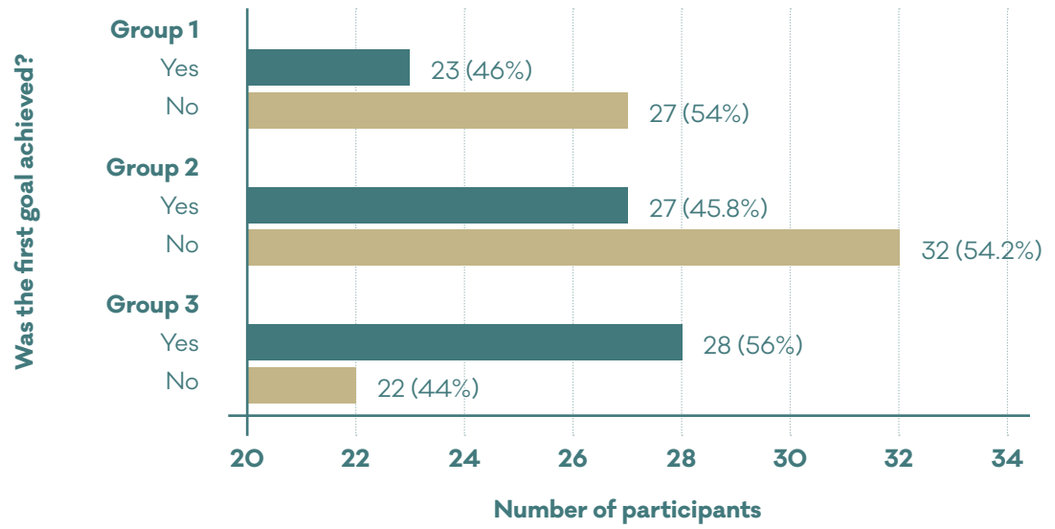


Figure 6: Was the first goal achieved at three-month follow-up?

their second goal (n=77), which was largely as expected, compared to those who reported not having achieved their goal by the three-month follow-up (n=73). Respondents from Group 3 seemed to be more likely than respondents in the other two groups to report having achieved their goal (58.7%, n=27).

More participants reported not having achieved their third goal (25.4% or 73) compared to those who had (19.1% or 55).

Setting new goals at three months

Participants set three new goals for themselves to achieve over the following three months. At this point in the evaluation, all participants would have been accessing a Your Way service for at least three months (Groups 2 and 3 may have been using the service for longer) and would have had some experience (and received some support) with setting personal goals as part of the goal attainment aspect of the Your Way model.

The largest proportion of participants from each of the three groups identified their first goal as related to employment, education and volunteering (Group 1: 24.5%, n=12; Group 2: 26%, n=13; Group 3: 20.9%, n=9).

Participants from Group 1 also frequently identified first goals related to housing, legal and financial issues (18.4%, n=9), closely followed by goals related to participants' mental health, medication and service use, and social support, family and community (14.3%, n=7).

Participants in Group 2 also frequently identified goals related to social support, family and community and personal development/sense of self (16%, n=8). Participants from Group 3 frequently identified first goals that were related to physical health and wellbeing (18.6%, n=8) and mental health, medication and service use (16.3%, n=7).

Participants across all three groups were likely to describe the achievement of their first goal as being 'very important' and 'very difficult to achieve'.

Participants from Group 1 most frequently identified a second goal related to physical health and wellbeing, and employment, education and volunteering (20.5%, n=9). This group were least likely to identify second goals related to mental health, medication and service use, and creative interests and hobbies (4.5%, n=2).

The second goals identified by participants from Group 2 were most frequently related to physical health and wellbeing (32.2%, n=15). Participants from Group 3 most frequently identified goals related to employment, education and volunteering (19.5%, n=8).[2]

Achieving goals at six months

At six months, 44 of all participants (27%, 44/163) responding at this time point achieved their first goal, particularly those in Group 1 (57.1%, n=16). However, 56 (34.3%, 56/163) participants reported not achieving this and a higher proportion of these were in Group 3 (54.5%, 18/94).

Overall, 17% (48/287) participants achieved their second goal and 16% (45/287) did not. Similar proportions were found for participants across each group regarding their second goal. Participants from Groups 1 and 3 who were unable to achieve their second goal were most likely to report their goal achievement as 'worse than before' (Group 1: 66.7%, n=8; Group 3: 60%, n=9).

A total of 39 participants (13.6%) reported achieving their third goal and 45 (15.7%) indicated they had not, which was similar across all three groups. Of those who achieved their third goal at the six-month follow-up, the largest proportion of participants across all three groups reported having achieved their third goal 'as expected', particularly in Group 2 (58.8%, n=10) and Group 3 (53.8%, n=7).

Achieving goals at 12 months

Despite fewer respondents at this time point, 34 (12%, 34/287) participants in total reported achieving their first goal. Most participants in Group 3 had achieved their first goal at 12 months (80%, n=16), while Group 1 showed less goal attainment at this stage (35.3%, n=6).

The majority of participants across all three groups reported having achieved their second goal at 12 months (Group 1: 57.1%, n=8; Group 2:

2. The number of respondents identifying their third goal at this three-month point were too few to analyse meaningfully.

56.5%, n=13; Group 3: 66.7%, n=12), with Group 3 showing the largest proportion of participants who had achieved their second goal. Twenty-seven participants achieved their third goal at 12 months, mostly in Groups 2 or 3 (Group 2: 65%, n=13; Group 3: 62.5%, n=10), but reported not having achieved this.

Hospital bed use

A total of 272 participants responded to the question regarding hospital bed use at baseline. Just under a third (28%, n=76) had at least one admission to psychiatric hospital in the previous year. The average length of admission was approximately 50 days.

Twenty-nine participants provided responses regarding admission to hospital at baseline and at 12 months. Of the nine participants that had an admission in the year prior to baseline data collection, the majority (n=6) had not returned to hospital in the subsequent year. Of the remaining three participants who had returned to hospital, one had been admitted twice with a total length of stay of 90 days.

Cost comparisons

A cost analysis was carried out to compare costs of the new service with existing services. The methodology drew on an approach previously used by the London School of Economics in partnership with the Mental Health Foundation for a community-based intervention (8).

Due to economies of scale, there is a difference between the average cost per person using the service and the *marginal* cost of each additional person using an existing service.

Service cost comparison data used

Costs were measured at 2011/2012 prices. Unit costs for health and social care services were sourced from the Personal Social Services Research Unit (PSSRU) Unit Costs of Health and Social Care 2012 (9) and NHS reference costs (10, 11). Where needed, unit costs were inflated using the Hospital and Community Health Services (HCHS) Pay and Prices Index (9).

Staff comparators used

Staff and service equivalents are used for cost comparisons, based on roles and functions performed, level of skill and training required and, where appropriate, salary levels.

Your Way service income models

Income from services supplied has been provided in five components: statutory grants, personal budgets, other grants, fundraising income and other income. The services reviewed here are commissioned using different funding models and funding sources. Some are block funded, e.g. some older contracts are paid a lump sum to provide a service against a specification, whereas others are funded on the basis of number of hours delivered or people supported. A small number are spot funded, i.e. bought on an individual basis as required by the commissioner. Some services are funded by individuals with personal budgets, and a relatively small number are self-funded. A number of services receive Supporting People funding and some services have a grant-funded component.

Your Way cost components

The costs associated with services include four components: staffing, property, administration and learning/development. Staff costs are the largest component.

Services are delivered in various settings including existing service buildings, community locations and people's own homes. Some locations have a rent cost, others are rent free but have responsibilities or commitments, and some use community buildings. Property costs are identified for each project for each year of operation. Some services have moved, or are moving, away from fixed physical locations.

The office and administrative costs are a relatively small component of the overall costs. Although currently small, effective peer support and, in particular, the development of people from service users to peer supporters to further careers needs to be considered.

Exclusions

The North and South Warwickshire services have been excluded as there is no comparison data available for the services provided.

Service	Cost per month			Cost per annum		
	Your Way	Statutory	Difference	Your Way	Statutory	Difference
Barnsley	£21,818	£35,334	£13,516	£261,817	£424,008	£162,191
Bexhill	£12,500	£27,288	£14,788	£150,000	£327,456	£177,456
Hastings	£12,500	£27,288	£14,788	£150,000	£327,456	£177,456
Reading	£16,250	£28,636	£12,386	£195,000	£343,632	£148,632
Rochdale	£14,917	£31,547	£16,630	£179,000	£378,560	£199,560
Shropshire	£9,000	£8,283	-£717	£108,000	£99,392	-£8,608
Southwark	£10,937	£6,821	-£4,161	£131,240	£81,856	-£49,834
Wandsworth	£10,937	£15,088	£4,151	£131,240	£181,056	£49,816

Table 4: Costs compared by service per month and per annum

Note that the statutory comparators for Southwark and Shropshire do not reflect the true cost that would be incurred if the Your Way services were being provided by statutory staff; the cost comparisons do not include the full cost of providing the support, just the hourly cost of equivalent staff time. The Your Way costs include the full cost of providing a service, including administrative and office costs.

The cost comparisons in Table 4 only provide a partial view of the transformation from traditional services to Your Way. The following analysis offers more details of the cost benefit changes in two settings, Wandsworth and Southwark, based on the cost of the services before and after transition.

In Wandsworth, up until 2009–2010, services consisted of traditional day care. 134 clients were supported annually at a cost of over £700,000. A tiny proportion of these people moved on to positive outcomes (three per annum). Following service transformation, more people are supported each year: 165 at a significantly reduced cost (reduced by more than £538,000 per annum). Crucially, a significant majority of these people moved on to more positive outcomes (101 in the year 2013–2014).

In Southwark, the transformation from traditional day care to Your Way took place a couple of years later and drew on the lessons learnt from Wandsworth. Before transformation, in 2011–2012 Southwark supported 94 people over the year at a cost of over £261,000. Following transformation, in the year 2013–2014, 82 people were supported with a cost reduction of over £87,000 per annum.

Participants' experiences of Your Way

Here we describe service users' experiences of Your Way both in relation to the model's five essential elements, and any perceived improvements to be made to the service. This is based on a total of 41 service users who participated in in-depth interviews, 14 of which completed both baseline and 12-month follow-up interviews. Qualitative interviews took place at five of the 13 evaluation sites: Hastings, Reading, Southwark, South Warwickshire and Wandsworth.

Community and social network

Participants across all sites described Your Way as a community of people, of staff and peers, who provide support to each other to stay healthy and well.

'I enjoy coming to Reading Your Way because people here understand you, and you don't have to explain an awful lot. And it's one of the few places I can come when I'm having a bad day. So the support I get from them is keeping me social and active and in a good routine.' (B8)

'What I've got from Wandsworth Your Way I'm passing on to other people. The community matters, and I'm part of that community. And I think now, I do matter myself.' (B10)

Some service users felt that receiving support from Your Way had helped them to expand their network of social support, particularly for those who had previously lacked this. For these service users, accessing Your Way had enabled them to reduce their social isolation, giving them the opportunity to engage with others who had experienced similar issues, and to discuss their mental health concerns.

'I don't isolate myself as much as I used to. I like to socialise more with people.' (F6)

'It's helped me break the isolation. It's just nice to have somewhere to come where you're understood and I don't need to explain myself. It's nice to feel understood.' (F7)

'It enables you to stop feeling so isolated within your own illness, and you are able to see that there are other people who are really successfully living with their illness, as well as some people who aren't having such a good time at the moment.' (B8)

An open-minded approach

The open-minded, open-access approach adopted by Your Way enabled respondents to view it as a safe space in which to seek support and advice on a daily basis, but also at times of increased need. Your Way staff and the service's community of peers helped to provide both practical and emotional support to respondents, helping them to feel less alone during periods of ill health. The flexible nature of Your Way support had also helped some respondents to re-engage back into the community.

'Your Way makes sure you're feeling OK. If you're down, you get to speak to them. Their phone is on 24/7.' (B11)

'I felt really unsafe and alone and isolated and overwhelmed by it all. The structure of coming here and knowing there is support, knowing that I'm not alone; I feel a measure of safety. It's like a coping thing.' (B7)

'It's a daily event, I can come every day. Before I came here I would never do art, I certainly wouldn't have done yoga, and I'm loving yoga at the moment. And to do it in a therapeutic environment that's safe with other people who are like you, you can't beat that. It's an essential part of my life.' (B8)

The value of peer support

Peer support takes place when people with experience of mental distress support each other towards better wellbeing, as people of equal value and on a reciprocal basis, using their own lived experience as a tool for support. Peer support is a core part of Your Way and, for many respondents, this was considered one of the most meaningful and helpful elements.

The provision of peer support was considered valuable by many participants; friendships were formed and participants felt better understood by their peer supporters.

'They're better friends than I've ever had actually. They've suffered similar things, if not the same thing, and we have an understanding.' (F5)

'Peer support is so valuable because the people [peer supporters] have felt it ... where you've been. By talking to a peer support worker, you know they've been where you've been, but they managed to get over it.' (F8)

'Years ago when I was very depressed, it got me out of the house, so that I could be with people that understood me.' (B4)

'If I didn't have that help, and also me helping other people as well ... I think I would be six feet under.' (B10)

More resilience

Participants reported having learnt a variety of approaches to managing their health and wellbeing from the Your Way team, including practical coping skills and day-to-day self-management techniques. For some, as part of an integrated package of care, support from Your Way staff had helped respondents avoid having to use acute mental health services.

The Your Way support provided a platform for participants to manage their mental health so that their illness was not perceived as an obstacle. The service also opened up potential employment or other opportunities for participants to become involved in.

'If I'm having a really, really bad crisis, I can always talk to my key worker. It might be a small crisis, so it just needs a 10-minute or 20-minute chat with my key worker which will calm me down and get me a bit more on track. It also helps avoid me needing the mental health service.' (B3)

'I'm currently nearly finished the bipolar course. I've just started the first of eight sessions in mindfulness, which I think will be life changing for me.' (B2)

'Volunteering in the café has helped me look at things in a different way, and possibly see an opening in a career, job or business that I would never have considered before.' (F2)

'The more they support you to work with yourself, the more you can start managing on your own.' (B6)

Participants spoke of feeling empowered to move forward in their lives, having developed an increased confidence in themselves and their abilities to do this.

'I can see a way ahead, now I've done the voluntary coordinators and also the peer support course, I've made two films which I'm proud of.' (B10)

'Your Way was a catalyst to starting me on my tracks.' (F9)

'I'm a lot more confident and I've come out of myself.' (F4)

Goal setting, an incremental process

The majority of respondents felt that support from Your Way had given them a renewed sense of motivation to pursue their personal goals. They highlighted the gradual and progressive nature of goal achievement, and how collaborative relationships with staff and peers supporters were integral to supporting this process. Respondents felt well supported in identifying and pursuing their personal goals, highlighting the importance of setting realistic, short-term goals initially, before exploring longer-term goals and aspirations. This approach enabled respondents to be more structured in identifying and setting personal goals, building their confidence over time.

'I believe that the stability I have been able to maintain since coming here for the last year has enabled me to go to college.' (B8)

'I can't really see that far in front, but yeah tomorrow, we can set a goal for tomorrow or maybe a few days' time.' (B3)

'My goals are much more lofty now than when I first came here; they were limited to just getting through the day without too much pain.' (F9)

One respondent reported that, of all the services they were currently accessing, it was the support from Your Way that provided the catalyst for change, meaning that they were finally able to turn things around for themselves.

'I've had so much support and counselling from different services ... and it's been Together which has actually been the catalyst for change.' (B17)

High-quality service

A number of participants described the high standard of services and quality of support that Your Way staff provided. The person-centred approach meant that service users' needs are listened to and put first.

'They always listen. That's what the staff are for. That's why I like it here. They always listen to me.' (B6)

'It's a different sort of support that I'd get from a therapist or a doctor. The understanding is already there.' (B7)

One respondent described how Your Way differed from other mental health services because it focused on their strengths and mental health recovery rather than their illness. Participants also described not feeling judged by staff and being treated as equals when interacting with Your Way staff.

'The support here is not so much about illness. It's more a wellness-directed thing and it's much more appropriate to me.' (B2)

'I've received a lot of help over the years but it's always been from professionals so they are sort of like "them" and "us" or "me" and "them". It wasn't an equal relationship.' (F7)

Service user-directed support

Participants were able to meet Your Way staff where they wanted and felt they were able to offer feedback on the support received, which would be taken on board.

'They've always said that if I didn't want to come here they would meet in a café or wherever I wanted to meet.' (B3)

'We are in control of what's going on.' (F14)

'All of my care, from everybody in my little circle, we are collaborative. I have a huge input into what happens to me, especially with medication and treatments and therapies and things.' (F8)

'People are free to put forward their opinions on what they would like to do, and the staff work very hard to get that sorted.' (F9)

Areas for service improvement

The lack of barriers in receiving support from Your Way was considered important for a number of participants. Your Way was perceived by some as different to other services in terms of its informality, being user-led and not having to discuss or disclose more information than felt comfortable.

However, some participants preferred earlier opening times for one Your Way service and out-of-hours support, particularly at weekends, which was no longer provided by one site.

'We used to get support, visits at the weekends, but that's changed. We only get a phone call at the weekends for my medication reminder. But we want to have a visit, somebody to visit at weekends.' (F13)

Another participant commented that Your Way needed more workers and resources as staff became busier and 'booked up' with other appointments, which, at times, limited their ability to arrange additional support. Despite this, the one-to-one support received was considered very positive.

One site (Wandsworth) originally operated out of two day resources centres before closing one and relocating to an administrative base only. This meant that some service users met with their Your Way support worker in a crowded café, which, at times, was not felt to be an appropriate environment in which to discuss confidential personal matters. It was reported that previously there had been ample space/rooms for having one-to-one meetings, and one participant preferred this setting to their home.

'It's good to have one-to-ones, and Alex [the Your Way support worker] comes to where I live and we go to a café. But when I have official letters, maybe sitting in a public environment isn't the best to have a conversation about benefits. Because you feel self-conscious that people are listening over your shoulder.' (B16)

Two participants highlighted the need for more support from Your Way with maintaining a healthy weight and improving their physical health.

'One of my targets is to try and deal with my weight and I know this is a common issue for people who take certain medications; I would like to see more activities for keeping yourself physically well.' (F9)

One younger respondent reported that they would like Your Way to offer a greater range of activities that were more appropriate for their age group.

'There isn't as much that I would like to do. There are no real groups that I can do. A lot of people that I've met are quite [a bit] older than me, so it's not like there's people around my age that like similar things.' (B16)

DISCUSSION

Wellbeing

Your Way provides an important person-centred service for people with a diagnosed mental health problem. The average wellbeing scores for all three groups (a mean average of approximately 37–41) at baseline were lower than that found for the general population of 52.5 (12). Yet, increases in wellbeing scores were found for all groups at three months and these were significant for Groups 1 and 2. Wellbeing scores appeared to plateau after six months. However, the relatively small number of follow-up participants, particularly at six- and 12-month follow-ups, may have contributed to the non-significant result.

Health-promoting lifestyle activity

Mean scores for health-promoting and lifestyle activities improved for Groups 1 and 2, but remained broadly similar across the different time points for Group 3. For people who enrolled on the evaluation within a month of accessing Your Way (Group 1), there were significant long-term improvements observed in relation to *social life and relationships, a sense of meaning, and relationships with health professionals*.

Patterns of goal setting and achievement

Physical health and wellbeing was the most frequently identified first goal across all three groups at baseline, and first goals were rated 'very important' for the majority of all participants. Goals set by participants in Group 2 were consistently and frequently related to *physical health and wellbeing*, as well as *employment, education and volunteering*. This pattern in Group 2 was stable across all time points for goal-setting opportunities (e.g. baseline, three-month, and six-month).

Group 3 had also consistently identified goals related to *physical health and wellbeing*, closely followed in frequency by goals related to *employment, education and volunteering*. In addition, Group 3 was the only group in which goals related to creative interests and hobbies had emerged as a common theme at baseline and six-month time points.

Interestingly, goals related to *personal development and sense of self* emerged as a common theme across all three groups only at six months. This may indicate that participants, or users of Your Way services, are more likely to set personal development goals after having used the service for some time and becoming accustomed to identifying and achieving goals.

It was also of interest that Group 1 was the only group with a higher focus on goals related to *social support, family and community*. This may suggest that social isolation is reduced and becomes less of a focus as users of Your Way services increase their access to social support opportunities. However, Group 1 may have also differed in other characteristics (as more recent members of the Your Way service), which may lend a higher propensity to focus on and identify goals related to improving *social support, family and community connections*.

The proportions of participants who achieved their goals differed across the time points. At three and 12 months, Group 3 showed the highest likelihood of achieving their goals. At six months, however, Group 1 showed the highest proportion of participants who achieved their goals. Group 2 also showed higher goal achievement than Group 3 at six months, although the number of participants were considerably reduced by six months and even more so at 12 months, making it difficult to draw firm conclusions about goal achievement.

An overall trend could be observed in the achievement of goals across all three groups as they showed an increased likelihood of achieving their goals at each follow-up interval, with the exception of Group 1's enhanced goal achievement at the six-month follow-up (as stated previously). This increase was most notable in participants'

achievement of their second goal at the 12-month follow-up, as a majority across all three groups had achieved their goal. This may suggest an incremental improvement in goal achievement over time as service users become more familiar with the goal-setting process, and progress in line with this aspect of the Your Way model.

Hospital use

It is difficult to draw any conclusions about whether Your Way was able to reduce admissions to psychiatric hospital as few participants provided information about this at 12 months.

Cost comparisons

Where Your Way has been able to work on a large scale, it may deliver these services at lower costs than statutory equivalents. This may allow them to reach more people and offer greater variety without increasing the costs.

Current financial and commissioning systems are not designed to provide even the most basic of value-for-money information. This work shows the possibility of making cost comparisons but cannot, in itself, allow commissioners to allocate resources and contracts on the basis of benefit per pound.

Further work is needed to allow such comparisons to be part of everyday commissioning, so that services can cost the full social and care contribution that services provide to their clients and communities that rely on them.

Participants' experiences

On the whole, the experience of using Your Way was very positive. Staff and peer supporters were valued in terms of the support they provided, and, for some participants, this provided the encouragement and motivation to move forward with their lives and to pursue work and training activities. Building resilience and increasing confidence were other important gains for participants.

Participants highlighted areas for improving Your Way, particularly around opening hours and providing out-of-hours support and a suitable venue for one-to-one meetings.

Also important was the need for more support in maintaining a healthy weight and improving the physical health of participants, despite the emphasis Your Way places on health-promoting lifestyle activities. This is an important consideration given the reduced life expectancy and physical health problems often associated with certain psychotropic medications (13).

Limitations and factors affecting the evaluation

Participant recruitment in the first year of the evaluation proved challenging. There was an overestimation of service users' willingness to participate in the evaluation and the capacity of local staff to recruit. Some sites tended towards low-level, outcome-focused, short-term support, which had a negative impact on longer-term engagement with the evaluation overall. As a result, initial data targets were recalculated from 600 service users to 300.

It was anticipated that evaluation participants would have recently begun accessing Your Way. In practice, this was not the case. Around a third of participants had been accessing the service prior to its transformation to Your Way, which made assessing the outcomes of the new service more difficult. However, participants from Group 1 show the 'true' impact of Your Way as they received their baseline assessments within a month of joining the service.

To some degree, the evaluation was aligned to the timetable for the rollout of personal budgets, which has been much slower than anticipated. The average actual take-up is around 53% across all care sectors, and for mental health the uptake of personal budgets has been markedly poor at 8.7% (14). This has had an adverse impact on the evaluation overall, as fewer potential service users have been able to buy Your Way services.

At the design stage of the evaluation, the majority of Your Way services were supporting people with moderate to severe mental health issues. The introduction of large-scale funding cuts has

resulted in significant changes to the eligibility criteria for Your Way, which currently caters for people with severe or critical mental health needs. In some areas, this has resulted in an overall reduction of those eligible to receive further support by 90%; hence, there were fewer new clients available to take part in the evaluation. Instead, many participants included in the evaluation had received Your Way for a relatively long period of time. In this respect, it is possible that the Your Way service had a less dramatic impact on the outcomes measured if used long-term, instead serving to maintain existing levels of subjective wellbeing and health-promoting lifestyle activity over time.

At some sites, contractual limitations prevented services from fully transforming into personalised services, and these therefore had to be excluded from the evaluation. This again reduced the number of potential participants to Your Way and, subsequently, the evaluation.

CONCLUSIONS

Your Way was developed to provide a personalised and recovery-oriented service for people experiencing mental health problems. This evaluation highlights the important findings in relation to improvements in wellbeing, health-promoting lifestyles and goal attainment.

There were huge challenges in conducting the evaluation given the differences across Your Way sites and the problems associated with participant recruitment.

On the whole, participants were positive about Your Way and felt understood by staff, and some were able to reduce their contact with statutory services with support from Your Way staff.

Cost comparisons between Your Way and other services appear to suggest some cost benefits if Your Way works on a large-scale basis or is provided as part of a broader range of services rather than in isolation.

It is not clear from the current findings whether hospital bed use was reduced, but there was some indication from qualitative interviews that service users were able to use Your Way to avoid acute care and reduce their reliance on mental health services.

Further work is needed to better understand how innovative, community-based support services can help support people with mental health problems and which groups benefit most.

RECOMMENDATIONS

'Every Your Way relationship starts with a conversation and a blank piece of paper.'

The personalised ethos and innovative approach of Your Way holds a substantial challenge to evaluation.

The following recommendations reflect these two challenges:

- Consequent variation of Your Way in different sites (in response to local needs, eligibility criteria, community characteristics and funding streams).
- External factors, such as the changing commissioning environment and the slow implementation of personal budgets.

1. **Your Way approach:** We recommend that Together continues to learn from the development of this approach, both in terms of the operation of the five essential elements and the totality of Your Way using an action research methodology within each site.
2. **Embedding the Your Way model:** We recommend that Together continues to embed the Your Way approach in ways that reflect funding streams and local differences within each site (including differences in service user profiles, staff backgrounds and skills, and the communities in which services are based).
3. **Development of an evaluation approach:** We recommend that Together and other service providers continue to develop evaluation approaches to personalised community mental health provision. For Your Way, this evaluation approach should develop flexibly in order to understand the following: (i) the developmental, 'transformation' and 'embedding' processes; (ii) the operation longer-term with regard to service-user leadership and sustainability. Future evaluations should include process and outcome components, and include the perspectives of staff (strategic, service management and front line), peer supporters and service users.
4. **Cost benefit analysis (CBA):** We recommend that the Department of Health invests in the independent development of a CBA approach for innovative voluntary sector provision in mental health. This will require government funding as it is beyond the resource and remit of individual service providers.
5. **Personal budgets:** We recommend that the UK Government, service providers, research and representative organisations review the rollout of personal budgets across the country for people with mental health problems, including people who experience episodic ill health. This review should consider the commissioning and (national and local) policy leadership required to develop innovative self-directed support models and services.

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APPENDIX 1

DETAILED FINDINGS FOR WELLBEING AND HEALTH-PROMOTING LIFESTYLE ACTIVITY SCORES

Table A1 shows the number of WEMWBS and HPLP II assessments collected from individual participants over the course of the evaluation by group.

	T1 (baseline)			T2 (3 months)			T3 (6 months)			T4 (12 months)		
	Group 1	Group 2	Group 3	Group 1	Group 2	Group 3	Group 1	Group 2	Group 3	Group 1	Group 2	Group 3
WEMWBS	91	107	91	60	67	64	35	49	42	16	30	23
HPLP II	89	106	90	61	66	65	35	48	40	16	28	22

Table A1: Assessments collected at each time point by group

Table A2 shows the number of participants that completed assessments over multiple time points by group.

	T1/T2			T1/T3			T1/T2/T3			T1/T4			T1/T2/T3/T4		
	Group 1	Group 2	Group 3	Group 1	Group 2	Group 3	Group 1	Group 2	Group 3	Group 1	Group 2	Group 3	Group 1	Group 2	Group 3
WEMWBS	60	67	64	35	49	42	31	38	33	16	30	23	10	12	14
HPLP II	61	66	65	35	48	40	30	37	32	16	28	22	10	10	14

A2: Participants completing assessments over multiple time points

Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)

WEMWBS	T1					T2					T3					T4				
	N	Min	Max	Mean	SD	N	Min	Max	Mean	SD	N	Min	Max	Mean	SD	N	Min	Max	Mean	SD
Group 1	91	14	64	37.6	10.2	60	18	68	40.5	11.1	35	20	60	39.8	9.9	16	28	66	39.8	9.9
Group 2	107	16	59	36.9	10.5	67	14	61	39.7	11.2	49	17	59	39.2	10.3	30	18	54	38.3	9.1
Group 3	91	14	70	41.1	11.6	64	17	70	42.5	11.7	42	15	59	39.5	10.4	23	21	66	41.2	10.4

Table A3: Wellbeing descriptives

Health-Promoting Lifestyle Profile II (HPLP II) (by subscale)

HPLP II – General Health	T1					T2					T3					T4				
	N	Min	Max	Mean	SD	N	Min	Max	Mean	SD	N	Min	Max	Mean	SD	N	Min	Max	Mean	SD
Group 1	89	1	4	2.18	.700	61	1	4	2.26	.681	35	1	4	2.29	.667	16	1	3	2.06	.680
Group 2	106	1	4	2.08	.664	66	1	3	2.20	.638	48	1	4	2.29	.617	28	1	3	2.04	.576
Group 3	90	1	4	2.31	.647	65	1	4	2.37	.651	40	1	3	2.23	.660	22	2	3	2.45	.510

Table A4: General health descriptives

HPLP II – Exercise	T1					T2					T3					T4				
	N	Min	Max	Mean	SD	N	Min	Max	Mean	SD	N	Min	Max	Mean	SD	N	Min	Max	Mean	SD
Group 1	89	1	4	2.27	.863	61	1	4	2.26	.934	35	1	4	2.34	.938	16	1	4	2.19	.834
Group 2	106	1	4	2.11	.887	66	1	4	2.35	1.074	48	1	4	2.38	.937	28	1	4	2.25	.887
Group 3	90	1	4	2.21	.942	65	1	4	2.29	.879	40	1	4	2.13	.853	22	1	4	2.31	.898

Table A5: Exercise descriptives

HPLP II – Food	T1					T2					T3					T4				
	N	Min	Max	Mean	SD	N	Min	Max	Mean	SD	N	Min	Max	Mean	SD	N	Min	Max	Mean	SD
Group 1	89	1	4	2.29	.710	61	1	4	2.33	.598	35	1	4	2.49	.742	16	1	3	2.44	.629
Group 2	106	1	4	2.12	.726	66	1	4	2.18	.783	48	1	4	2.29	.743	28	1	3	2.18	.612
Group 3	90	1	4	2.50	.797	65	1	4	2.31	.789	40	1	4	2.40	.841	22	1	4	2.45	.739

Table A6: Food descriptives

HPLP II – Social Life	T1					T2					T3					T4				
	N	Min	Max	Mean	SD	N	Min	Max	Mean	SD	N	Min	Max	Mean	SD	N	Min	Max	Mean	SD
Group 1	89	1	4	2.43	.620	61	1	4	2.61	.802	35	1	4	2.83	.707	16	1	4	2.81	.750
Group 2	106	1	4	2.61	.763	66	1	4	2.47	.749	48	1	4	2.52	.743	28	1	4	2.50	.694
Group 3	90	1	4	2.74	.680	65	2	4	2.72	.625	40	1	4	2.68	.730	22	2	4	2.77	.685

Table A7: Social life descriptives

HPLP II – Health Professionals	T1					T2					T3					T4				
	N	Min	Max	Mean	SD	N	Min	Max	Mean	SD	N	Min	Max	Mean	SD	N	Min	Max	Mean	SD
Group 1	89	1	4	2.56	.673	61	1	4	2.75	.830	35	1	4	2.83	.785	16	1	4	2.88	1.025
Group 2	106	1	4	2.67	.765	66	1	4	2.56	.747	48	1	4	2.58	.821	28	1	4	2.61	.685
Group 3	90	2	4	2.82	.758	65	2	4	2.78	.696	40	1	4	2.70	.791	22	2	4	3.00	.756

Table A8: Dealing with health professionals descriptives

HPLP II – Finding Meaning	T1					T2					T3					T4				
	N	Min	Max	Mean	SD	N	Min	Max	Mean	SD	N	Min	Max	Mean	SD	N	Min	Max	Mean	SD
Group 1	89	1	4	2.12	.636	61	1	4	2.52	.808	35	1	4	2.51	.702	16	1	4	2.50	.894
Group 2	106	1	4	2.27	.775	66	1	4	2.36	.816	48	1	4	2.42	.794	28	1	4	2.21	.738
Group 3	90	1	4	2.52	.722	65	1	4	2.60	.806	40	1	4	2.48	.716	22	1	4	2.55	.739

Table A9: Finding meaning descriptives

HPLP II – Lifestyle Profile	T1					T2					T3					T4				
	N	Min	Max	Mean	SD	N	Min	Max	Mean	SD	N	Min	Max	Mean	SD	N	Min	Max	Mean	SD
Group 1	89	1	3	2.30	.531	61	1	3	2.43	.531	35	1	3	2.60	.553	16	1	3	2.44	.629
Group 2	106	1	3	2.25	.499	66	1	4	2.33	.616	48	2	3	2.40	.494	28	1	3	2.32	.548
Group 3	90	1	4	2.50	.566	65	2	4	2.58	.583	40	1	4	2.50	.641	22	2	4	2.55	.596

Table A10: Lifestyle profile descriptives

APPENDIX 2

GOAL CATEGORIES CODING SCHEME

1. **Physical health and wellbeing**

   Goals related to seeking medical or physical healthcare (e.g. physiotherapy), lifestyle changes (e.g. healthy eating, establishing regular sleeping patterns) and improving physical health and wellbeing (e.g. exercise, losing weight).

2. **Mental health, medication and service use**

   Goals related specifically to the treatment of mental health problems, such as improved adherence to medication, reduction in medication dosage or seeking professional mental health support.

3. **Social support, family and community**

   Goals related to connecting with family, friends or other members in their community, including repairing damaged family relationships, spending more time with family/friends, and using social support services within the community.

4. **Creative interests and hobbies**

   Goals ranged from wanting to travel more, visiting museums, painting and gardening, to finding a hobby and exploring new interests.

5. **Employment, education and volunteering**

   Goals included all levels of study, finding employment and/or voluntary work, and improving employability or developing work-related skill sets, such as building a CV.

6. **Housing, legal and financial**

   Goals related to accessing housing or resolving financial or legal issues, as well as seeking advice or support with managing money and seeking social security benefits.

7. **Life skills/independence**

   Goals included any aspect of managing day-to-day living (e.g. organising, cleaning, shopping) and increasing levels of independence and capacity (for example, using the train to go to London).

8. **Personal development/sense of self**

   Goals related to development or improvement of coping skills, self-management techniques and personal development. These goals ranged from wanting to gain confidence or achieving a sense of calm, to finding ways of reducing self-harming behaviours. Some were reflective in nature, with participants aiming to develop a sense of 'peace' or 'contentment' in order to contribute to a positive sense of self.

Group 1 HPLP II scores

Statistically significant increases were observed in the following subscales:

Social life

A non-parametric test indicates that increases in mean 'social life' score at each of the three follow-up time points were statistically significant:

- T1 (mean=2.36)/T2 (mean=2.61) n=61 (Z=-2.383, P<.05)
- T1 (mean=2.46)/T3 (mean=2.83) n=35 (Z=-2.681, P<.01)
- T1 (mean=2.31)/T4 (mean=2.81) n=16 (Z=-2.828, P<.01)

Finding meaning

A non-parametric test indicates that increases in mean 'finding meaning' score at each of the three follow-up time points were statistically significant:

- T1 (mean=2.15)/T2 (mean=2.52) n=61 (Z=-3.315, P<.01)
- T1 (mean=2.14)/T3 (mean=2.51) n=35 (Z=-2.707, P<.01)
- T1 (mean=1.94)/T4 (mean=2.50) n=16 (Z=-2.496, P<.05)

Dealing with health professionals

A non-parametric test indicates that increases in mean 'dealing with health professionals' score were significant at the following time points:

- T1 (mean=2.49)/T2 (mean=2.75) n=61 (Z=-2.747, P<.01)
- T1 (mean=2.54)/T3 (mean=2.83) n=35 (Z=-1.968, P<.05)

Lifestyle

The mean HPLP II 'lifestyle' score for the 35 participants that completed the HPLP II at both T1 and T3 increased from 2.31 at T1 to 2.6 at T3. A non-parametric test indicates that this increase was significant (Z=-2.673, P<.01).

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