Social recovery therapy for young people with emerging severe mental illness: the Prodigy RCT

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Plain English summary

The Prodigy RCT

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Plain English summary

Young people with social disability and non-psychotic severe and complex mental health problems are an important group. Their problems are often long-standing and they often have difficulty doing 'structured activity', such as work, sports and leisure activities (e.g. going shopping or to the cinema). They often avoid such activities because of anxiety or low mood. Other barriers may include financial and practical issues, and stigma from activity providers. Non-participation in structured activity increases the risk that mental health problems will continue and prevent these young people from reaching meaningful goals.

We tested whether or not social recovery therapy might help. This is a talking and activity therapy, in which young people (participants) work individually with a social recovery therapy therapist. Social recovery therapy aims to help participants identify what activities they would like to do, practise spending more time doing them, and work through barriers to maintaining increased activity. By improving structured activity, young people feel more hopeful and better able to manage their symptoms. However, social recovery therapy has never been evaluated properly using the best research methods. The best way to evaluate treatments like this is a randomised controlled trial in which participants are allocated by chance, like tossing a coin, to have the new therapy or not to have the therapy. Both groups are followed up for a period to see if the new therapy works. We tested social recovery therapy in this way. We also tested whether or not it was cost-effective.

We recruited 270 16- to 25-year-old participants in Sussex, East Anglia and Manchester. Participants had non-psychotic severe and complex mental health problems (not psychosis) and were doing < 30 hours of structured activity per week at the start of the study. All participants had enhanced standard care. This involved standard NHS treatment plus a full assessment and feedback from the study team, and a best practice guide to local support services that encouraged the best provision of standard evidence-based interventions. Half of the participants were randomly allocated to have social recovery therapy in addition to enhanced standard care over 9 months. All participants were invited to assessments 9, 15 and 24 months later. Therapists recorded the tasks and activities undertaken with participants. We asked both participants and therapists what they thought of the trial and the social recovery therapy.

We found no evidence that adding social recovery therapy improved outcomes. Participants in both arms made large and clinically worthwhile improvements in structured activity and mental health outcomes. If anything, there was some evidence that people allocated to enhanced standard care improved more than those allocated to social recovery therapy plus enhanced standard care. The differences were small, however, and could have occurred by chance.

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This report

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