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Preliminary Findings Evaluation Report: Mountsfield Recovery House as a Mental Health Intervention

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Contents

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Executive summary

This report summarises the work undertaken in preparation for a full evaluation of the Mountfield Recovery House (MRH) commissioned by the South London and Maudsley NHS Foundation Trust (SLaM). This evaluation was not undertaken due to financial pressures.

The report is based on information collected from meetings, observations and visits to the House and SLaM sites, and discussions with key stakeholders, supplemented by a literature review. It has been prepared by Dr Julie Williams and Maria Milenova with support from Professor Claire Henderson, Dr Amy Ronaldson and our Experts by Experience Steering Group made up of four patient representatives.

Overview of findings

The Recovery House model provides a community-based alternative to inpatient mental health care, aligning with the UK's recovery-oriented mental health policies. Our preliminary findings indicate that guests benefit from a structured, person-centred approach, with tailored interventions to develop coping skills, self-care routines, and recovery pathways. The peer support coordinator plays a critical role in maintaining guest engagement and ensuring follow-up care post-discharge.

However, making referrals to the Recovery House is a complex process and can lead to delays, particularly due to multi-step approvals and miscommunication between Emergency Departments, Home Treatment Teams, and the Recovery House. Improving these processes could enhance timeliness and efficiency. Short stays (six nights, seven days) may limit recovery for some guests, suggesting the need for peer mentorship programmes or extended post-discharge support.

Issues of equity and access remain unclear due to limited demographic and outcome data, making it difficult to assess who benefits most from the service. Additionally, geographical placement can create barriers for guests traveling from outside their home borough as currently the House serves Lewisham, Croydon, Lambeth and Southwark. A full evaluation is needed to assess long-term impact, cost-effectiveness, and the role of Recovery Houses in reducing reliance on hospital inpatient care, ensuring the model's sustainability and scalability within the NHS.

> ***"The foundation of any successful Recovery House is the commitment, dedication and mindset of the staff, which was transparently instant on my recent visit to the House.***
>
> ***The pride, the energy, the passion and the ambition are so profoundly overwhelming; it is also very inspiring. Though the Recovery House is still at the early stages, the potential is endless. With time and financial backing, it will make a huge difference to people and the community of Lewisham. That gives those in crisis a great opportunity and platform in positive steps to recovery, stability and hope."***
>
> *Expert with Lived Experience of Mental Ill Health*

1. Introduction

The Recovery House in South London

The Recovery House in Southeast London supports people experiencing a mental health crisis and is an alternative to hospital admission. This model aims to help people to learn to manage their mental health by providing support from staff, including individual and group interventions.

The House opened in September 2023 and is run by the charity Waythrough (formerly Richmond Fellowship charity) with clinical input from SLaM.

The Recovery House has six beds. Admissions are for a maximum of six nights and seven days. It is staffed 24 hours. Staffing consists of support workers, a peer support worker, a service manager for Waythrough and a service manager for SLaM.

Referrals come from any SLaM service in the four boroughs of Croydon, Lambeth, Lewisham and Southwark and are initially triaged and referred to the House by the Lewisham Home Treatment Team (HTT) from 8am until 10pm. From 10pm until 8am the Acute Referral Centre (ARC) refers potential guests. The House staff have the final say on who is admitted.

The Recovery House does not admit people who are considered a risk to themselves or others, who are under any section of the Mental Health Act, who need a full-time carer due to their disability, are homeless and/or actively using alcohol or other substances.

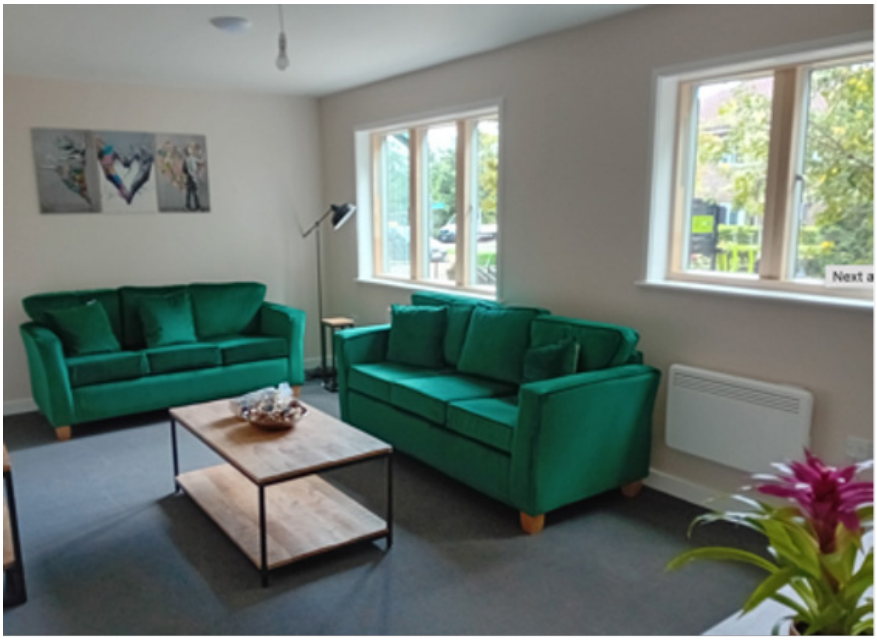
The House offers a safe place for people who need help to manage a mental health crisis with the aim of promoting recovery, to help guests to regain belief in themselves and to keep well at home. The Lewisham HTT provides clinical support with HTT staff visiting at least once daily and guests (the preferred term instead of “patient”) are empowered to:

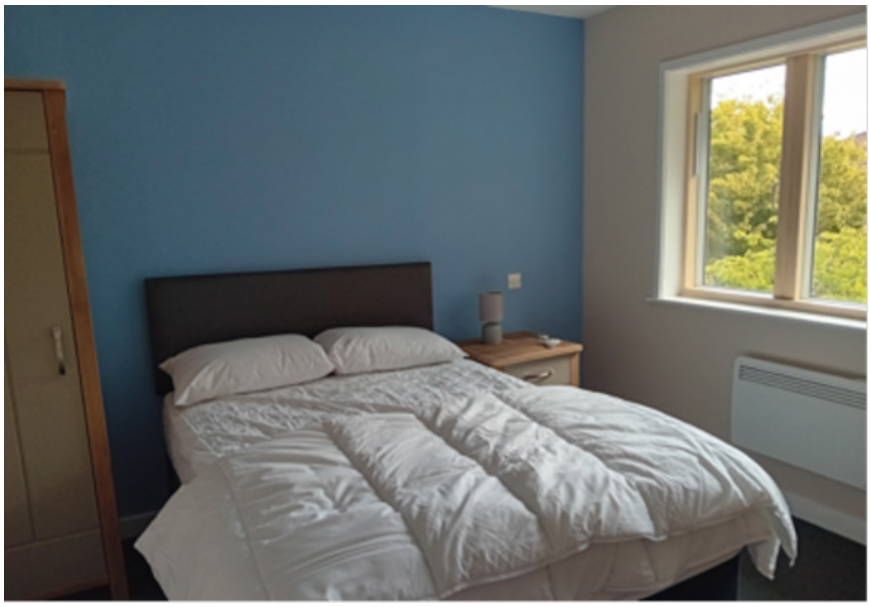
- develop their own coping skills
- build their resilience
- take control of their lives

Guests can get help from a range of personal interventions, focused on their recovery. These include:

- Support to learn and develop practical skills to safely return to independent living
- Support to ensure families/carer and/or other significant others are included in their care
- Support to manage their treatment
- Support to address physical health needs
- Interventions to understand relapse prevention
- Interventions to develop coping strategies
- Support to access employment/education/voluntary work or other social support structures.

Photos: Leanne Bower





The Recovery House living room and one the six bedrooms

The House is not locked, and guests are able to come and go as they please. The HTT and Recovery House staff help guests to develop their own recovery plans, including follow up activities post-discharge (such as phone calls and referrals to community support services). The ethos of the House is to support guests to be as independent as possible.

Initial data collection

JW and MM undertook preliminary data collection from April to September 2024 to prepare for the evaluation. This included individual and group meetings with key stakeholders, attending existing meetings, and visiting the Recovery House. A patient and public involvement (PPI) group was set up with four people with their own lived experience of using mental health services. A statistician advised on aspects of the evaluation. This planned evaluation aimed to evaluate the Recovery House using the Six STEEEP domains of safety, timeliness, effectiveness, efficiency, equity, and patient-centeredness and to develop recommendations for the continued implementation of the Recovery House in SLaM. The evaluation plan can be found on page 16.

This report is based on this preliminary data collection and consists of:

- Observational notes from 10 Recovery House visits and interactions with staff, management, and stakeholders
- Insights from 15 meetings with the PPI group including visiting the Recovery House
- Discussions with Recovery House staff and management, SLaM's Home Treatment Team and other referrers, and SLaM management.

Role of Experts by Experience Group

The Experts by Experience Group have made a significant contribution to the project and to this report. They worked on refining the survey and interview questions we were planning to use in the evaluation, visited the Recovery House and talked with staff there, and provided their insights and perspectives. All four experts have co-authored this report.

2. Reflections using the STEEEP domains

Although we have not been able to carry out the evaluation as planned, below we outline some our preliminary findings and reflections using the STEEEP domains (safety, timeliness, effectiveness, efficiency, equity, and patient-centeredness).

STEEEP: Safe

The Recovery House has risk assessment procedures in place as part of the referral and admission process. When a new guest is admitted, a Crisis Service Assessment Form (a tool used to evaluate a person's situation and identify the best course of action) and a Wellness Recovery Action Plan (WRAP) are administered. The WRAP is a self-designed process that helps each guest develop a safety plan to address mental health and other health issues. In addition, other documentation is completed in regard to risk and safety including: a Self-Administered Medication Form; an Agreement for Mountsfield House (reviewing the House rules); a Self-Discharge Form (e.g. if the guest decides to leave early); a Missing Person's Form (mainly for the police); a Consent to Store and Disclose Information; a PEEP form (fire safety and evacuation); and a Crisis Prevention Plan (similar to the Crisis Service Assessment Form, focussing on assessing a guest's triggers and warning signs).

The regular submission of the SLaM PEDIC patient experience form enables the recording of both positive and negative feedback, which aims to ensure that any safety concerns are identified and addressed promptly. Guests can submit anonymous comments after their stay using a QR code placed at the entrance of the House.

We have anecdotal feedback from staff that many guests report feeling safe and supported during their time at the Recovery House.

The peer support coordinator has been a particularly significant figure for guests. During their stay, the coordinator meets with each guest regularly to identify their needs and guide them through next steps, such as finding suitable employment, connecting with local recovery services or support groups, or strengthening their coping mechanisms. This proactive approach has been instrumental in fostering a sense of safety and stability for guests.

Some challenges related to safety have been identified. These include:

- The lack of full and up-to-date information in EPJS (the SLaM electronic patient record system) can make it harder to establish a comprehensive safety profile for referrals, potentially delaying or complicating admissions. The profile of new referrals needs to be carefully considered so it matches the profile of current guests to prevent safety issues or discrepancies between the HTT and the Recovery House staff.

- The partnership between SLaM HTT and Recovery House staff is a cornerstone of the service. Both teams bring unique expertise and perspectives—clinical and social care—that together ensure a well-rounded approach to supporting guests.

Maintaining this balance requires ongoing communication and collaboration, particularly when navigating decisions about admissions. Both the HTT and Recovery House staff are well placed to assess whether a guest's needs align with the level of support available in a non-clinical setting. However, steps need to be taken to prevent incidents where guests who have needs beyond the House's intended scope of care have been admitted.

- Concerns about guests potentially misusing the service—for instance, exaggerating symptoms to gain repeated access—highlight the need for stricter and more consistent admission criteria.

Despite these challenges, the combination of structured feedback mechanisms, compassionate staff, and a robust follow-up system contributes significantly to maintaining a safe and supportive environment for guests at the Recovery House.

S**T**EEEP: **Timeliness**

The referral process to the Recovery House involves multiple steps, which when efficiently coordinated, can take as little as four hours to admit a new guest to the House. However, inefficiencies or miscommunication can result in significant delays, with the referral process from the Emergency Department (ED) to the Recovery House sometimes taking several days. These delays can leave patients waiting in ED beds unnecessarily, creating additional strain on emergency services. A key bottleneck is that all new referrals, including those from other Home Treatment Teams with sufficient clinical expertise (Croydon, Southwark, or Lambeth), must go through the Lewisham HTT for assessment, which adds an additional layer of processing.

For example, the Lewisham HTT often rely on receiving an email communication followed by a phone call to ensure the information has been received and acted upon, but phone call follow-ups from ED or other HTTs are not always made, further compounding delays. Additionally, issues with incomplete or outdated information in EPJS can slow the referral process, as key details about a patient's history or suitability for the Recovery House may be missing.

Efforts to improve timeliness include recent initiatives to foster early contact between Recovery House staff and patients when they are at ED. This involves a member of staff speaking over the phone with prospective guests before their arrival at the House, which helps to reduce fear and uncertainty about the process. Another proposed improvement is allowing ED patients to see for themselves what the Recovery House looks like, which could give them reassurance about what to expect (e.g. make a video, paper or online brochure with pictures of the House available).

ST**E**EEP: **Effectiveness**

The effectiveness of the Recovery House relies on a combination of key factors: its emphasis on recovery-focused interventions, the expertise and compassion of staff, the integration of peer support, and the tailored, person-cantered care plans that help guests transition back into their communities. Guests at the Recovery House are encouraged to develop coping skills, establish self-care routines, and build improved mental health recovery pathways. A central feature of the House's

approach is its structured group interventions, designed to equip guests with practical tools for managing mental health crises and fostering resilience. Success stories highlight the impact of the Recovery House, such as instances where guests formed lasting friendships and continued to support each other through informal networks after discharge. These outcomes point to the role of social connection and peer support as key 'ingredients' in the House's effectiveness.

The peer support coordinator plays a critical role in enhancing the service's long-term effectiveness. During a guest's stay, the coordinator works collaboratively with them to create tailored recovery plans, often linking them to recovery colleges, local employment centres, or other community resources to support their reintegration into daily life. Post-discharge, two to three follow-up calls are made to guests during the first week and again at three months. These provide some continuity of care, helping to ensure guests remain connected to support systems and maintain progress in their recovery journey. These personalised interventions may contribute to the Recovery House's effectiveness as a crisis intervention service.

However, short stays (limited to six nights, seven days) were identified by Recovery House staff and the PPI group as a potential barrier to achieving sustained recovery for some guests. The time-limited nature of the intervention may not always allow for the depth of support needed, particularly for guests with complex needs or who require more time to stabilise and build effective coping strategies. For instance, staff have noticed that on average it takes a new guest about two days to adapt to the House. They have also noticed that guests experience low mood for two days before being discharged. This leaves three days for a guest to work on their Support Plan and focus on recovery uninterrupted.

STE**E**EP: **Efficiency**

Collaborative relationships between SLaM and Waythrough staff play a critical role in the efficient management of the Recovery House. Waythrough provides operational oversight (looking after the guests 24/7), while SLaM ensures clinical alignment (referral, discharge and medical treatment), creating a well-balanced partnership that supports the House's day-to-day operations. While the gatekeeping mechanisms are designed to ensure suitability and safety, the lack of a streamlined process can create bottlenecks, particularly when communication between teams is delayed or incomplete. For instance, when a new member of staff joins ED in one the four borough the House serves, they are frequently unsure of the guidance around referrals, in which case they send an email to both Recovery House staff and the Lewisham HTT for information.

STEE**E**P: **Equity**

The Recovery House does not currently accommodate individuals with severe disabilities, such as those requiring full mobility support or extensive personal care. While one room is designed for wheelchair users, the service overall does not provide assistance to those with more complex physical health needs (e.g. if someone is not able to dress themselves).

Guests are referred to the Recovery House from four boroughs: Lewisham, Croydon, Southwark and Lambeth. However, geographical placement can create significant challenges, particularly when guests are placed far from their family or established support networks. For example, individuals who do not live in Lewisham but are referred to the Recovery House may experience additional stress due to travel or being disconnected from local resources. This issue might be lessened if other recovery houses were created for each borough.

Currently, there is limited data on who is using the Recovery House and, importantly, who isn't. Without demographic data on those referred but not admitted (or those admitted but shouldn't have) it is difficult to fully assess the equity of the service. For instance, individuals on a section under the Mental Health Act are not eligible for admission to the Recovery House, raising questions about whether this model effectively addresses the needs of the full spectrum of SLaM's patient population. Individuals requiring a higher level of care may instead be admitted to inpatient units, but the lack of alternative options for step-down or community-based care might leave a gap for this group.

STEEE**P**: **Patient-Centredness**

We have anecdotal feedback that guests consistently appreciate the Recovery House's patient-centred approach, which emphasises individual recovery and the development of practical coping skills. From the moment a new guest arrives, they are given a personalised handwritten letter welcoming them to the House. A Crisis Support Plan with interventions is designed, tailored to the guest's needs. Each guest can choose from a "menu" of activities what they would like to focus on during their stay (e.g. self-care routines, group-based activities, and structured recovery plans developed in collaboration with staff). The Crisis Support Plan starts with setting a goal which is reviewed every day during their stay. This individualised focus helps foster a sense of empowerment and progress for guests. The Recovery House's deliberate refusal to label itself as a "crisis house" further reflects its patient-centred ethos, shifting the focus from crisis management to supporting guests on their recovery journey and building long-term resilience. Each guest has a standalone appointment with a member of staff from the HTT every day, which is mandatory.

To ensure that guests have a positive experience, staff are continually working to improve what the House offers. For example, they are exploring the potential for involving past guests as peer mentors or volunteers to provide additional support and guidance to current guests. Peer mentoring has been identified as an opportunity to enhance the recovery process by allowing current guests to learn from individuals who have navigated similar challenges. This peer-driven approach aligns with the broader recovery-oriented model and could significantly improve the sense of community and shared understanding within the House.

Feedback mechanisms, such as a suggestions box, the QR feedback poster at the entrance of the House and SLaM PEDIC forms, are central to the Recovery House's commitment to patient-centredness. These tools allow guests, their family and friends to share their experiences, provide constructive feedback and suggest areas for improvement. However, additional data could be collected to deepen the understanding of guest and staff experiences (e.g. surveys and

interviews to understand staff perceptions of their roles, challenges and ideas for enhancing the services offered).

Staff have also identified the need for more flexible pathways for individuals in unique circumstances, such as those at risk of experiencing homelessness or complex social challenges. Developing targeted interventions for these groups informed by guest feedback and staff experience, could further enhance the House's patient-centeredness.

> ***"For me personally, I can only imagine how beneficial a resource like the Recovery House might have been when I first began struggling with my mental health. If such a safe and supportive space had existed, I truly believe it could have acted as a preventative intervention—a place where I could confront and understand my emotions, explore why I was feeling so depressed, or why my anxiety felt so overwhelming.***
>
> ***Instead, due to the lack of resources, my mental health spiraled out of control. What began as manageable struggles escalated into severe mental illness, compounded by suicidal thoughts, self-medication with alcohol, and the devastating grip of dependency. These secondary struggles made it even harder to access the right support and treatment, creating a vicious cycle that took years to break.***
>
> ***I believe that services like the Recovery House have the potential to break that cycle before it begins. For others, this space could mean the difference between intervention and crisis, or even death. It could be the safe haven they need to pause, reflect, and regain control of their lives before things escalate to a point where they feel they have no options left. With the right resources, caring staff, and time to heal, the Recovery House could prevent so much unnecessary suffering and offer a brighter, healthier future to so many."***
>
> Expert with Lived Experience of Mental Ill Health

3. Summary of key findings

Although we were unable to complete a full evaluation, our reflections from the preliminary data collection are reported here. We found that the Recovery House model demonstrates significant strengths as a community-based alternative to inpatient mental health care, aligning well with the UK's recovery-oriented mental health policy goals.

It emphasises patient autonomy, recovery-focused interventions, and community reintegration, while reducing reliance on hospital services. Anecdotal feedback identified that guests feel supported by compassionate staff, benefiting from tailored interventions, such as coping skills development, self-care routines and structured recovery plans.

The inclusion of the role of a peer support coordinator enhances the service's effectiveness by providing personalised guidance and follow-up support post-discharge, incentivising long-term stability and recovery.

Strong collaboration between SLaM and Waythrough charity staff underpins the efficient management of the House, balancing clinical oversight with operational support. However, inefficiencies in referral processes, including delays and miscommunication between ED, HTT, and the Recovery House, highlight the need for streamlined workflows and better communication. Similarly, discharge processes are time-intensive and could benefit from improved coordination.

As we have not been able to collect even anecdotal data on equity, we do not know how it is addressed. We have limited information on who is referred, admitted or excluded outside of the general admissions criteria, which prevents us from comprehensively assessing accessibility and inclusivity. Geographic placement can create a stress for guests referred far from their support networks, highlighting the need for more localised Recovery Houses.

Short stays (six nights, seven days) may limit recovery for some guests, particularly those with complex needs who might end up become repeat users of the House over time. Initiatives such as peer mentorship programmes and extended post-discharge support could address this gap.

Feedback mechanisms, such as SLaM PEDIC forms and guest suggestions, help to ensure patient-centeredness, but more robust data collection on guest and staff experiences, as well as long-term recovery outcomes, is needed to strengthen the evidence base. By addressing these challenges and leveraging its strengths, the Recovery House model has the potential to further embed itself as a key component of the UK's mental health care landscape, promoting recovery and reducing the burden on inpatient services.

4. Recommendations

We propose some recommendations which might support the ongoing improvement of the implementation of this Recovery House model in SLaM.

1. Improving the referral process

- The current referral process could be simplified to reduce delays, inefficiencies and miscommunications between all stakeholders (e.g., Recovery House staff, ED, Lewisham HTT, and other HTTs from all other three boroughs). A streamlined referral and discharge process may improve the overall timeliness of care.

- Increasing awareness of the House among referring services is advisable by improving staff knowledge and understanding of the House's purpose and processes.

- Consider allowing direct referrals from GPs or other community services to reduce reliance on Lewisham HTT as the sole gatekeeper, provided there are safeguards in place (e.g., clinical review of referrals).

- Consider introducing a new member of staff with clinical expertise (e.g. from SLaM) to assess all referrals, improve decision-making confidence, and streamline admissions without increasing staff workload. This could reduce bottlenecks and improve guest suitability.

2. Enhancing safety

- Continue to monitor and refine risk assessment procedures, ensuring that all admissions align with the needs of current guests and capacity of Recovery House staff to avoid conflicts and safety risks. Support the staff at the House to ensure the team can feel confident in managing crises while maintaining a welcoming and recovery-focused ethos.

- Provide staff with ongoing support and training to handle challenging situations and ensure resilience in service delivery. Strengthening referral pathways, enhancing communication, and clarifying roles in the admission process could help mitigate potential risks while maintaining the collaborative nature of the service.

3. Strengthening peer support

- Develop a stronger peer mentor network to provide additional support to guests. This could consist of a peer-support network made of mentors who themselves have been guests.

- Peer mentors could welcome new guests, accompany them on walks, and share recovery experiences to build confidence and provide practical guidance.

- Offer peer mentors ongoing training and support to ensure consistency and effectiveness in their roles.

- If expanding the duration of stays is not possible due to capacity, offering more structured follow-up programmes post-discharge, could address this gap and further enhance outcomes.

4. Increasing visibility and awareness

- Improve the online presence of the Recovery House by ensuring it can be found on search engines (e.g., Google) and providing clear contact information for inquiries (e.g., a dedicated information email for public queries). If this is not deemed suitable or safe due to the nature of the service provided, an improved more accurate description can be provided on SLaM or Waythrough website (e.g. https://www.waythrough.org.uk/find-support-near-me/slam-crisis-house/).

- Consider creating a virtual 360-degree tour of the House to help potential guests, families and staff better understand what the House offers and reduce apprehension (e.g. using the following video by Waythrough as a template: https://www.youtube.com/watch?v=IhUAfBQGbXw).

- Use accessible and inclusive language in promotional materials, replacing terms like "service users" with phrases such as "people experiencing mental health distress" to foster a more respectful and recovery-oriented tone.

5. Data collection and evaluation

- If an in-house evaluation is possible, we recommend collecting detailed demographic and outcomes data on who is using the House, who is being referred but not admitted, and reasons for exclusions. This will help assess equity and effectiveness. Gathering longitudinal data on outcomes such as post-discharge stability, use of secondary mental health services and community integration would help to evidence the House's impact.

- To better evidence the effectiveness of the Recovery House, additional data could be collected such as clinical outcome measures (e.g., DIALOG and HoNOS scores pre- and post-stay) to track improvements in mental health. Longitudinal data on guests' use of secondary mental health services (e.g., future inpatient admissions, ED visits) could be used to assess whether they experience reductions in service utilisation.

- Documenting success stories from guests would help to showcase the benefits of the Recovery House model. This could be done by working with current and past guests to obtain consent and share their experiences.

6. Building links with other services

- Strengthen partnerships with complementary services, such as housing providers, employment support, financial/legal advice services and recovery colleges, to provide guests with holistic care.

- Stronger coordination with complementary services in south London (e.g. housing, physical health services, financial and legal advice) can lead to better support for guests. The multiple times a person in a crisis needs to repeat their

story to multiple service providers (and at times multiple people within each service) has been flagged as an issue.

7. Enhancing guest experience

- Expand the range of activities offered, including one-on-one meetings with staff, social, cultural and/or nature-based activities to promote health awareness, in addition to the current structured group sessions.

- Allow recently discharged guests to return to the House for part of the day (e.g., until mid-afternoon) for a limited period to continue participating in group activities and maintain support networks.

- Provide additional resources for guests, such as self-help books, newspapers, magazines and plants to create a welcoming environment. These can be donated by local shops and businesses in the area.

- Consider creating designated spaces for smoking and relaxation to improve comfort for guests.

- In addition, staff have identified that there could be benefits to allowing guests to come back to the House until mid-afternoon (e.g. 15:00) for three days after being discharged. This way they could continue working on their recovery, while feeling that they still have some support mechanism and take part in group activities (e.g. life skills, budgeting).

5. Conclusion

The Recovery House model represents a valuable, community-based alternative to inpatient care, aligning with the UK's recovery-oriented mental health policies. Our preliminary findings highlight its strengths in promoting autonomy, fostering recovery through tailored interventions and reducing reliance on hospital services.

For South London and Maudsley NHS Foundation Trust (SLaM), our preliminary findings emphasise the critical role the Recovery House plays within the broader mental health landscape. It provides a vital link between acute care and community support, potentially reducing pressure on inpatient services and supporting individuals in crisis. However, to maximise its impact, improvements in referral processes, equity of access, integration with complementary services and follow-up support are essential.

Given the significance of this service and its alignment with national policy priorities, we strongly recommend a comprehensive evaluation of the Recovery House model. A full evaluation would validate these initial findings and provide robust evidence to inform future improvements, ensuring that the Recovery House continues to meet the needs of its diverse population. By addressing gaps in data collection and exploring long-term outcomes, such an evaluation would not only strengthen the service itself, but also offer insights for similar recovery-oriented initiatives across the NHS.

This work is critical to ensuring the sustainability and scalability of this promising model, enhancing care for those experiencing mental health crises and supporting SLaM's commitment to high-quality, equitable and patient-centred care.

Appendix I: **Original evaluation plan**

1. Introduction

This evaluation focuses on the Recovery House based in Lewisham in Southeast London. This evaluation has been commissioned and funded by the South London and Maudsley NHS Foundation Trust (SLaM) who have commissioned and funded the House.

2. Evaluation objectives

The primary objective of this project is to evaluate the Recovery House in Southeast London. The aims of the evaluation are to understand the following:

1) Safety: we aim to understand (i) how safety and risk are managed in the Recovery House and by the local HTT who provide clinical support to the Recovery House, and (i) how guests and staff perceive safety.

2) Timeliness: we aim to evaluate the referral and admission process of the Recovery House, including guest and staff perceptions of this process.

3) Effectiveness: we will evaluate the impact of the Recovery House on patient outcomes, including clinical, recovery, and personal outcomes where possible to obtain this data.

4) Efficiency: we aim to evaluate the efficiency of the Recovery House, including economically and in terms of bed usage.

5) Equity of service provision: we will evaluate whether the Recovery House is reaching all populations equitably and whether the care provided is equitable for all groups within the predetermined geographic location.

6) Patient-Centeredness: we will evaluate whether the support given at the Recovery House is respectful and responsive to the needs and preferences of the guests.

The secondary objective of the evaluation is to develop a set of recommendations to improve the use, acceptability and access to the recovery house; a set of recommendations for policy development and contribute to further improving the recovery house model in the UK.

This research will use a mixed-methods approach using both qualitative and quantitative data. Data will be used to address each aim (Patton, 2015). The evaluation objectives have been developed in collaboration with Waythrough and SLaM, and refined in consultation with experts by experience who are part of a public-patient involvement (PPI) group.

The data for each domain will be collected and analysed as follows:

Safety

We will:
- Analyse DATIX reports (SLaM routine risk reporting register)
- Analyse Recovery House reports
- Analyse untoward incident reports
- Ask about safety in our interviews with Recovery House guests, carers and staff
- Ask about this in the surveys we will invite guests and staff to complete.

Timeliness

We will:
- Review SLaM data on referrals and admissions
- Analyse Recovery House data on admissions
- Conduct interviews with Recovery House guests and staff to understand their experiences with the referral and admission process
- Interview referrers to the Recovery House including Accident and Emergency and HTT staff to understand their experience of referring to the Recovery House
- Ask Recovery House guests (and their carers) about their experience of being referred and admitted to the Recovery House during our interviews with them
- Ask Recovery House staff about their experience of guests being referred and admitted in our interviews with them
- Ask about this in the surveys we will invite guests and staff to complete.

Effectiveness

We will:
- Use routinely collected clinical data in SLaM using the CRIS system to compare patient outcomes for Recovery House users and matched controls. We will do this at two time points — October 2024 and July 202 — to understand any changes in outcomes due to any changes in the Recovery House processes
- Ask Recovery House guests (and their carers) about their views on how the Recovery House has impacted on their lives, including any changes to their personal and recovery outcomes related to their Recovery House stay
- Ask about this in the surveys we will invite guests and staff to complete.

Efficiency

We will:
- Conduct an economic evaluation of the Recovery House, including the cost of running, the house versus SLaM inpatient unit costs, and to understand bed use in the Recovery House
- Analyse cost savings or increases in other parts of the healthcare system, such as reduced hospital admissions or emergency department visits
- Use SLaM economic and CRIS data and Recovery House data on bed usage to assess cost-effectiveness.

Equity

We will
- Aim to collect a comprehensive set of demographic data of guests from the Recovery House to ensure inclusivity and equity in our analysis. This data will encompass protected characteristics as defined by the Equality Act 2010, including age, gender, gender reassignment, marriage, pregnancy, disability, race, religion or belief, and sexual orientation and also geographic location, socioeconomic status, diagnosis and neighbourhood deprivation). We will compare this data with the demographics of SLaM inpatient admissions
- Ask guests (and their carers) if they felt they were treated equitably in our interviews with them and ask staff about this in our interviews with them
- Ask about this in the surveys we will invite guests and staff to complete.

Patient-centredness

We will:
- Ask Recovery House guests (and carers) and staff about their experiences and perceptions of the care provided in the interviews we do with them and how patient-centred they felt that House was
- Ask about this in the surveys we will invite guests and staff to complete.

Data collection

1. Guests of the Recovery House:

- In-depth interviews: 20% of guests at the Recovery House who meet the eligibility criteria will be invited to take part in a semi-structured one to one interview with one of the researchers. We will use a stratified convenience sample based on the gender, ethnicity and age demographic profile of Recovery House guests. We will ask the Recovery House to give us anonymised demographic data each month and choose people to interview from this to ensure our interviewees are representative of the Recovery House demographic as possible. The interviews will be conducted after the guest leaves the Recovery House. The interviews will take place at either the guest's home, their community mental health team, King's College London premises, or online (via MS Teams). The interviews will be recorded with permission, and transcribed.
- Guest survey: All people who have been guests at the Recovery House and meet the eligibility criteria will be invited to complete a survey either on SurveyMonkey or in a paper version which will use a Likert Scale (1-10) to quantitatively assess aspects of Recovery House provision and their experience.

2. Carers:

- In-depth interviews: we will conduct interviews with 10 carers of guests of the Recovery House. We will ask all guests that we interview if they have a carer and will ask them to let their carer know about the study and if they would be happy to be interviewed. If they are, a researcher will contact them to give them an information sheet and let them ask any questions. If they are happy to, they will be asked to give written informed consent. Interviews will take place at either the guest's home, their community mental health team, King's College London premises, or online (via MS Teams). The interviews will be recorded with permission and transcribed.

3. SLaM Service Managers (Including Referral Staff from ED), Home Treatment Team, and Recovery House staff:

- In-depth interviews:
- 10 HTT staff from the Lewisham HTT will be invited to take part in interviews. The questions will ask about how they work with the Recovery House and its staff, how effective and efficient they think the Recovery house is, and their views on the safety, timeliness, equitable and patient-centred of the House.
- Accident and Emergency and HTT staff from the four boroughs who refer to the Recovery House will be invited to take part in an interview. The interviews will ask about their experience of referring to the Recovery House, their perceptions of the Recovery House, and their perceptions of the overall impact on patient care. We will aim to interview 10 staff who have made referrals from across the four boroughs that make referrals.
- All staff at the Recovery House will be invited to take part in an interview. The interviews will ask about their views on how the Recovery House works, how they work with Lewisham HTT, and other referrers, how the Recovery House impacts on patient outcomes and any areas for improvement.
- SLaM managers and Waythrough managers who have had involvement with the Recovery House in their role will be interviewed to find out about how SLaM and the Recovery House work together, their expectations of the Recovery House, and future plans.
- Staff survey: all staff will be invited to complete a survey using SurveyMonkey which will use a Likert Scale with a scale of 1-10. The survey will be administered online.

4. Routinely collected data:

We will collect patient outcomes data from both SLaM and the Recovery House, including:

- DATIX
- Untoward incident reports
- Bed occupancy rates
- Patient outcome data

For the effectiveness aim, we will use routinely collected data from the Clinical Record Interactive Search (CRIS) database at SLaM to undertake a retrospective matched cohort study. Recovery house guests will be identified in CRIS and we will identify matched controls in order to assess the impact of staying at the Recovery House. We will match people on the following if possible:

- Age
- Gender
- Ethnicity
- Current diagnosis
- When first had contact with SLaM
- Borough
- Neighbourhood deprivation
- Not under any section of the Mental Health Act
- Not currently using alcohol or drugs

The outcome data that we wish to compare are:

- Number of inpatient admissions
- Number of bed days per admission
- Use of HTT, PICU
- Mental Health Act sections
- Future diagnoses
- DIALOG scores
- HONOS scores

Analysis plan:

- Qualitative Analysis: We will use thematic analysis to identify common themes and patterns in the interview data. We will develop a coding framework based on the STEEEP domains. We will code the data using software (either MAXQDA or nVIVO) to organise and analyse responses. We will analyse the interviews as we conduct them.
- Quantitative Analysis: We will analyse survey responses using descriptive statistics to measure central tendencies and variations (mean, median, standard deviation).
- CRIS data analysis: We will use the routinely collected data housed in the Clinical Record Interactive Search (CRIS) database at SLaM to create a retrospective matched cohort study to evaluate the effectiveness of the Recovery House. This will involve identifying a control group and employing propensity score matching (Rosenbaum & Rubin, 1983) using the CRIS system. This is a statistical matching technique that attempts to create a comparable control group for the people who stay at the Recovery House by accounting for the covariates, such as demographics and clinical history, that predict outcomes. We will identify the same number of control participants as there are Recovery House patients. Appropriate linear, logistic, and negative binomial regression models will be used to assess the impact of Recovery House attendance on outcomes.
- Economic data analysis we will assess the costs of the Recovery House per admission and compare this to the costs for a comparable SLaM inpatient admission.
- Mixed-Methods Analysis: We will combine qualitative and quantitative findings to evaluate each of the STEEEP domains. We will synthesise the findings into a comprehensive report, highlight key insights and provide actionable recommendations based on the data.

Patient and public involvement (PPI)

We have set up a PPI group with four members who have worked with us to design the topics guides for interviews and the surveys. We will meet with them monthly, and they will provide input and feedback to the data we collect. They will work as a 'critical friend' and we will update them on progress and initial and ongoing findings.

Timelines

The evaluation will be conducted over a period of five quarters (April 2024-Sep 2025) addressing each of the aims of the study, with activities spanning each quarter. Please see flowchart below for more details of the evaluation's timeline. Some of the aims and activities in each quarter might overlap due to the interconnectedness of the aims and the nature of the study.

Appendix II: **Literature review of recovery in mental health**

The process of recovery in mental health has gained increasing recognition and prominence in policy and practice over the past couple of decades. A shift in mental health services towards supporting personal recovery is recommended internationally (World Health Organization, 2021) and is now central to healthcare policy in many countries (Mental Health Commission of Canada, 2012, HM Government, 2011, 2017).

In the UK, recovery emphasises a person-centred approach, focusing on an individual's ability to live a fulfilling life despite the challenges posed by mental health conditions (National Service Framework for Mental Health (NSF), 1999; Mental Health Policy Implementation Guide (MHPIG), 2001; Mental Health Act, 2007; The NHS England's Five Year Forward View for Mental Health, 2016). The journey to recovery is a 'deeply personal, unique process' (Anthony, 1993) involving 'the reclamation of personal power' (Coleman, 2011) in areas such as identity, hope, meaning, choice and empowerment (Slade, 2009). The crisis house model, also known as a recovery house, offers an innovative approach to mental health crisis intervention. Already piloted internationally, it serves as an alternative to traditional hospitalisation (Dorozenko, 2019). Recovery houses provide short-term residential support for individuals experiencing acute distress.

The Recovery House Model in the UK

'Traditional' mental inpatient services have been criticised for being a distressing experience for people with mental health conditions. These services do not help people to recover, are busy and untherapeutic, and there patients can feel powerless and have inadequate communication with staff (Butterworth et al., 2022).

The Recovery House model eliminates stress. Stress is not healthy for recovery, and puts limitations on individuals, because depression can be induced by hospitals. A Recovery House is healthier for recovery and promotes independent living in general, and belief in oneself, and unlike hospitals, it reduces depression and anxiety. Recovery House models and similar community-based services have had an evolving role as alternatives to inpatient care. They can offer a less restrictive environment and focus on short-term crisis interventions that prioritise patient autonomy and peer support.

Supporting mental health recovery has been a policy aim in the UK since 2001 and the importance of stable housing for people with mental health problems has been recognised for some time which the UK government acknowledged in a policy paper in 2011 (HM Government, 2011). Currently, the NHS mental health system's recovery model emphasises building resilience and the role of family and professionals in supporting people's identity and self-esteem.

Several studies highlight the positive outcomes associated with recovery crisis houses for patients including reductions in hospital admissions, improvements in mental health symptoms, and increased patient satisfaction. One evaluation

(Ryan et al., 2011) reported improvements in mental health symptoms and functioning among guests at Amethyst House, a crisis house in Liverpool. Other evaluations, like the review by (Paton et al., 2016), also provide evidence for the cost-effectiveness of crisis houses, though findings regarding long-term impacts remain mixed.

The literature also identifies limitations and variability within the recovery crisis house model. For example, (Dalton-Locke et al., 2021) discuss regional variations in crisis care models across England, which may contribute to inconsistent service delivery and outcomes. There is also inconsistency in the terminology used when talking about recovery or crisis houses within healthcare system, third-sector or charity-led initiatives, social and other mental health organisations using terms such as “recovery house”, “crisis house”, “recovery crisis house”, “crisis respite”, “crisis resolution”, and “crisis accommodation” interchangeably. Alternatives can be dreadful to some individuals.

Issues related to recovery crisis house interventions

According to the literature, there are several issues related to the implementation of the recovery house model. Studies such as those by (Butt et al., 2019) highlight the need for standardised outcome measures, as partnerships between crisis houses and home treatment teams sometimes yield variable results in terms of patient safety and mental health outcomes.

Addressing equity in service provision is another key theme. Morant et al. (2013) and Lawlor et al. (2013) examine ethnic disparities in access to crisis services and variations in compulsory admissions, suggesting that Recovery Houses could play a role in mitigating inequalities in mental health care pathways. The Recovery House model, as described by authors like Howard et al. (2010), emphasises a recovery-oriented approach that aligns with UK mental health policy but requires careful attention to ensure that services are inclusive and accessible to diverse populations.

Recovery requires a natural process which should become more possible with the right type of care, which medication by itself is not able to take care of.

The literature also suggests the importance of integrating Recovery Houses with broader mental health services to create a seamless continuum of care. Johnson et al. (2022) advocate for flexible crisis care systems that can meet varied patient needs. This integration, as highlighted in several studies, may enhance both patient and staff satisfaction and strengthen therapeutic alliances within crisis intervention settings.

There are potential benefits of Recovery Houses as effective crisis intervention models that promote patient autonomy and reduce the need for inpatient care. However, challenges related to equity, regional variation, and long-term outcome data persist, indicating a need for further research and more standardised evaluation methods.

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Find out more about KIS: www.kingsimprovementscience.org

Find out more about King's Health Partners: www.kingshealthpartners.org

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