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"Hospital at Home" Mental Health Psychiatric Hospital Return to the Community Transition Support: Impact on Self-Reported Wellbeing

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Abstract

Background: People who are discharged from mental health psychiatric hospitals often have low average levels of wellbeing and require support to improve wellbeing, enable mental health recovery, and facilitate successful transition back into the community to prevent mental health crisis and readmission. Low levels of wellbeing are linked to worse mental health symptoms, anxiety, and depression. Intervention: Hospital at Home is a two-week intervention that provides at-home support for people who are discharged from a mental health hospital or who are at risk of a mental health crisis and hospital admission. It is a trauma-informed, behaviour-change, and strengths-based approach; staff provide individualised practical and emotional support, identifying needs and goals to help individuals stabilise, build confidence, develop and apply coping strategies, recover, self-manage, connect with community-based services and resources, and reconnect with previous social contacts and activities. Purpose/aim: This study investigated the impact of Hospital at Home on wellbeing. The study addressed the question: "What is the impact of Hospital at Home transition support on self-reported psychological wellbeing?" Methods: An open-label patient cohort design with no control group was used. Pre- and post-intervention assessments were conducted using the self-report measure, the Short Warwick–Edinburgh Mental WellBeing Scale (WEMWBS). Participants were 102 Hospital at Home clients, 28 (27.5%) males and 74 (72.5%) females. The average age of the participants was 50.1 years (range 25 to 95 years; SD = 14.8). Results: Prior to the start of participation in Hospital at Home, 89% of participants reported low wellbeing, with only 11% reporting in the normal range of wellbeing. At the end of participation in Hospital at Home, 54% reported in the normal range of wellbeing and 2% in the high range of wellbeing. SWEMWBS scores significantly improved by 5.52 points (SD = 4.05) with a very large effect size (Cohen's d = −1.36). SWEMWBS scores significantly improved in partici-

pants with a primary diagnosis of anxiety by 5.44 points (*SD* = 4.14) with a very large effect size (Cohen's d = −1.31). SWEMWBS scores significantly improved in participants with a primary diagnosis of depression by 5.28 points (*SD* = 3.76) with a very large effect size (Cohen's d = −1.40). SWEMWBS scores significantly improved in participants with a primary diagnosis of schizophrenia by 6.60 points (*SD* = 3.79) with a very large effect size (Cohen's d = −1.74). Conclusion: Hospital at Home was found to be beneficial in terms of improving wellbeing, which is linked to improvements in mental health. The SWEMWBS results indicate improvements in optimism, self-efficacy, calmness, coping, clarity of thinking, closer connections with others, and personal agency, which can enhance a successful return to the community, mental health recovery, and reduce the risk of relapse and readmission. Hospital at Home is relatively low-cost and can be offered by all mental health providers. Further research is justified to support roll-out.

Keywords

Severe Mental Illness, Depression, Schizophrenia, Anxiety, Physical Activity, Sleep, Health Coaching, Mental Health Recovery, Community, Wellbeing, Mental Health Hospital

1. Introduction

Severe Mental Illnesses (SMI) are defined as having a mental health diagnosis that causes severe psychological problems, functional, and occupational impairment (diagnoses can include, for example, psychosis, schizophrenia, bipolar disorder, Major Depressive Disorder (MDD)); the prevalence of SMI in adults in England is 0.9%: over 400,000 people (Public Health England, 2018). Experiencing long-term SMI can result in a reduced life expectancy of 15 to 20 years (Hjorthøj et al., 2017), highlighting the need for support for adopting healthy lifestyles (Griffiths et al., 2024). People with SMI experience lower average levels of wellbeing compared to the general population, and this is linked to higher levels of anxiety and depression (Shah et al., 2021). Interventions that employ resilience, self-management, and wellness techniques have the greatest impact on improving wellbeing (Blodgett et al., 2022).

In the United Kingdom's (UK) National Health Service (NHS), there is a principle of the "promotion of recovery and social inclusion" for people with SMI: "services should take active steps to promote recovery and the social inclusion of service users and help to improve their life chances, including helping them back to work" and "services should focus on a person's strengths with the aim of improving quality of life and community involvement" (CSIP, 2007: p. 12). There is also a principle of "Individualised whole-person care": "people should be supported to maintain their independence." (CSIP, 2007: p. 12) There is a requirement to provide services in the NHS that meet these principles (CSIP, 2007).

Around 10 percent of people leaving inpatient psychiatric wards are readmitted

within 28 days (Health Committee, 2013), and around 20 percent are readmitted within 6 months (Osborn et al., 2021), indicating the need for effective interventions to support people after discharge to reduce readmission. Reasons for readmission include not having an effective discharge plan (Callaly et al., 2010) and a lack of one-to-one support following discharge to facilitate community reintegration, promote recovery, and prevent future mental health crises (Griffiths et al., 2015). If transition back to the community is not effectively supported, it is likely to be detrimental to a person's mental health recovery and may impact negatively on readmission rates (Griffiths et al., 2015). With the high cost of psychiatric inpatient admissions, there is a strong economic argument for investing in effective support for successful transition back home and into the community (McCrone et al., 2008; Okorie et al., 2011).

If investment is made in effective one-to-one support for transition to the community, there can be a reduction in psychiatric readmission (Vigod et al., 2013). Components of effective post-discharge interventions include providing psychoeducation that targets mental health self-management and independent living, needs assessments, medication reconciliation/education, staff skilled in supporting transition, support for follow-up appointments, and regular home visits (Vigod et al., 2013). NICE (2011) recommends that when a person is discharged from a psychiatric ward to the community, there should be effective collaboration between healthcare providers and any involved family members and caregivers, and that the person is provided with information about and links to appropriate community-based resources and support options. NHS England (2025) requires that early relapse warning signs are identified and post-discharge follow-up with the patient is carried out within 72 hours of discharge to ensure the right discharge support is in place; this visit requires co-working with the person and their support network and defining the need for further home visits and from whom.

Support for successful reintegration into the community should assess and address needs in relation to financial, occupational, and social factors (Gerson & Rose, 2012). To reduce the risk of experiencing a mental health crisis and prevent hospital readmission, patients value support for individual coping measures, meaningful activities, and developing social networks (Katschnig et al., 2017). There has been an acknowledged need for community-based mental health staff to establish trusting and positive relationships with people with mental health issues they work with, and those supporting them (e.g., caregivers, family, and friends) (NHS England, 2023). Staff also need to have good local knowledge of and links with community-based services, groups, charities, and other resources to identify opportunities for the person and to facilitate access (NHS England, 2023). A systematic review found that barriers preventing successful community reintegration were disconnection due to hospitalisation, poverty, interpersonal difficulties, and stigma; the review identified the need for effective transitional interventions that target these challenges, such as enhancing safety, supported autonomy, and the opportunity to engage in reintegration activities (Mutschler et al., 2019).

Loneliness and a lack of social connections are often experienced by people with SMI (Beebe, 2010); they tend to have smaller social networks than the general population (Brunt & Hansson, 2002; Forrester-Jones et al., 2012; Middelboe et al., 2001). Therefore, they have less access to social support, social capital, and opportunities for social inclusion (Breier & Strauss, 1984), which are important factors for mental health support workers to seek to enhance and facilitate mental health recovery. Family reconnection and support can be a crucial factor in recovery from a mental health crisis (Saunders, 2003). Positive social interaction and support can provide people with beneficial factors such as reality testing, social approval and integration, constancy (connecting current with pre-hospital identity and re-establishing existential roots), motivation, symptom monitoring, problem solving, empathetic understanding, reciprocal relating, and insight (Breier & Strauss, 1984).

Upon return to the community, people will need support to deal with a variety of challenges and problems, some of which may have contributed to their hospital admission (Griffiths et al., 2015). Compliance with prescribed psychiatric medication and attending follow-up appointments are common difficulties for people with experience of SMI living in the community (Beebe, 2010). Mental health recovery is partially contingent on the reduction and stabilization of the symptoms of mental illness and the acquisition of the skills (social, self-management, daily tasks of living) necessary to function successfully in the community (Schooler, 2006).

Successful transition back into the community can also require support in reconnecting people to regular activities (volunteering, work, education, hobbies, sports) that they previously engaged in, or working with them to identify and support engagement in new activities (Griffiths et al., 2015). Engagement in meaningful activities is an important factor in motivation, self-efficacy, quality of life, mental health recovery, and preventing hospital readmission (Cuyún Carter et al., 2011; Goldberg et al., 2002; Hendryx et al., 2009). Following discharge from a psychiatric hospital, people often wish to engage in more and new meaningful activities (Gerson & Rose, 2012).

Supporting the adoption of regular routines and a healthy lifestyle (which can include regular physical activity, healthy meals, and nighttime sleep) can be beneficial (Sheldon et al., 2025). For people with SMI, engaging in physical activity is associated with improved quality of life, cognition, functioning, and physical health, as well as reduced psychotic symptomatology (Mittal et al., 2017). A good night's sleep (approximately 7 to 8 hours) is associated with wellbeing, happiness, social relationship satisfaction, feeling energised, improved mental health, and ability to cope; these factors are related to mental health recovery and engaging in and enjoying life (Waite et al., 2016; Griffiths et al., 2022a; Griffiths, Walker, & Leathlean, 2022b). Having regular healthy meals can result in improved physical health, sleep quality, functioning, and physical activity (Watkins et al., 2020; Hargens et al., 2013). A virtuous cycle can result whereby regular healthy meals, good nighttime sleep, and physical activity result in greater self-esteem and confidence, which further enhance motivation and capability to engage socially and in healthy lifestyle activities and therefore enhance mental health recovery (Car-

ney et al., 2017).

Psychological barriers to healthy lifestyles include psychotic symptoms, anxiety, depression, low motivation, and low self-efficacy (Brooke et al., 2020; Carney et al., 2017). Additional barriers include social withdrawal due to poor mental health, stigma, fear of others, and low self-esteem (Carney et al., 2017). There can be practical issues and barriers to adopting a healthy lifestyle, such as cost, time, and insufficient skills and knowledge (Carney et al., 2017). Mental health services can work with people with SMI to help overcome these barriers (Griffiths et al., 2024).

Motivational support and goal-setting are effective tools for mental health recovery and for motivating people to engage in healthy lifestyle behaviours (Hardcastle et al., 2015). Interventions to enhance motivation for healthier lifestyles can help elicit long-term mental health recovery and healthy lifestyle behaviour change (McGrane et al., 2015). Applying behaviour change theory can foster self-efficacy and increase the likelihood of intervention efficacy (Smith et al., 2020).

A systematic review found that various interventions to support transition from acute mental health services to the community have been tested, encompassing a heterogeneous group of interventions and study outcomes (Tyler et al., 2019). This highlights the need for more targeted research, with structured and standardised interventions, in order to help identify the mechanisms that make these interventions effective (Tyler et al., 2019). A systematic review found that transitional care interventions helped to reduce the likelihood of readmission to hospital by 1.7 times, but the review identified a scarcity of transitional care interventions (Birtwell et al., 2022). A scoping review of interventions for people with psychotic symptoms transitioning from inpatient to community care found that support should include educational and relational elements (Nunes et al., 2025).

This present study investigated the impact of Hospital at Home, a service providing two weeks of one-to-one individualized at-home transitional support for people who have been discharged from a mental health hospital and returned to the community, as well as support for those at high risk of mental health crisis and admission. The study addressed the question: "What is the impact of Hospital at Home on self-reported wellbeing?" Our hypothesis was that Hospital at Home would have a positive impact on psychological wellbeing.

2. Methods

2.1. Design

Open-label patient cohort design with no control group.

2.2. Participants

The sample was recruited from people using the Hospital at Home service within the UK's NHS. Participants were included if they were aged 18 or over, had the mental capacity to consent, and provided informed consent. The exclusion criterion was refusal to engage with Hospital at Home. There were no exclusions based on diagnosis, demographics, or clinical history.

2.3. Service Description

Hospital at Home was co-produced/co-designed by the Mind mental health charity and an NHS Trust by service managers, mental health practitioners, carers, and people with lived experience of mental health issues. The service operates from 9:00 AM to 9:00 PM, seven days a week.

Hospital at Home is a hands-on support service delivered in people's homes for those recently discharged from a mental health hospital or identified by the NHS as at high risk of mental health crisis or readmission. A trauma-informed, behaviour-change, and strengths-based approach is utilised. Staff provide individualised practical and emotional support to help individuals stabilise, build confidence, develop and apply coping strategies, recover, self-manage, reconnect with previous social contacts and activities, become independent, and prevent mental health crisis and hospital readmission. It provides practical assistance to set up and manage daily tasks, attend appointments, and engage with wider community-based services, groups, activities, and support. To achieve this, staff engage with and listen to the client's description of their circumstances and needs, conduct personalised assessments, risk evaluations, support and care planning, and goal-setting. Support, advice, and links in relation to education and/or work are provided if required. Staff apply skills to enhance motivation and build a therapeutic relationship. Discharge is planned collaboratively with the client, with tapering contact and follow-up phone calls for a month; all clients are provided with contact information for relevant support services.

The frontline staff are supported by the service lead. No formal qualifications are required, but all staff receive training in supporting clients at home, self-harm and suicide prevention, safeguarding, risk assessment, trauma-informed strengths-based care, lone-working, and safety protocols. Staff develop an understanding and knowledge of, and connections with, community-based services, groups, organisations, and resources.

2.4. Approval

The data collection was undertaken from October 2023 to August 2025. Approval for the intervention was obtained from the providers of the service (Reference number for approval: H@H2025). The study was conducted in accordance with the Declaration of Helsinki (World Medical Association (WMA), 2025). Informed consent was obtained to receive Hospital at Home.

2.5. Procedure

The NHS trust refers the patient, who is informed of the service and consents to receive support, and then a home/community-based assessment occurs within three days of discharge. Following consent, medical records are accessed for relevant clinical history. The first contact is made via phone to arrange a home visit. At the data collection points (referral/assessment and immediately post-discharge from Hospital at Home) participants complete the self-report measure. All Hos-

pital at Home clients who were approached consented and there was no loss to follow-up. The service is funded by the NHS.

2.6. Measure

The Short Warwick-Edinburgh Mental Well-Being Scale (SWEMWBS) is a 7-item version of the 14-item Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) self-report measure of psychological wellbeing, which has been found to be valid, reliable, and acceptable (Tennant et al., 2007; Mack, Vo, & Wilson, 2024), responsive to change, and suitable for evaluation of interventions at the individual level (Maheswaran et al., 2012). The SWEMWBS (Stewart-Brown et al., 2009) is made up of seven items that assess mental well-being: "I've been feeling optimistic about the future"; "I've been feeling useful"; "I've been feeling relaxed"; "I've been dealing with problems well"; "I've been thinking clearly"; "I've been feeling close to other people"; and "I've been able to make up my own mind about things". Items in this self-report scale are rated on a five-point Likert-type scale response format from "None of the time" (score of 1) to "All of the time" (score of 5). All responses are added together and transformed into metric scores to get the total response score, with higher scores indicating greater levels of mental well-being. The SWEMWBS has been found to be valid, reliable, acceptable, and sensitive to change (Shah et al., 2021).

2.7. Methodology and Analysis

Normality and other paired t-test assumptions were checked. There were no missing SWEMWBS data. T-tests were conducted to determine whether there were statistically significant differences in SWEMWBS. Data were analysed using the statistical software package SPSS Statistics 31.

3. Results

3.1. Participant Characteristics

74 (72.5%) participants identified as female, and 28 (27.5%) participants identified as male. The average age of the participants was 50.1 years (range 25 to 95 years; $SD = 14.8$). Table 1 lists participant ethnicity, Table 2 lists participants' primary and secondary mental health diagnoses, and Table 3 lists levels of wellbeing.

Table 1. Ethnicity.

Ethnicity	Number (Percentage)
White British	77 (75.5%)
Black African Caribbean	10 (9.8%)
White Eastern European	6 (5.9%)
White Irish	4 (3.9%)
Asian Bangladeshi	3 (2.9%)
Mixed African	2 (2.0%)

Table 2. Primary and secondary mental health diagnoses.

Diagnosis	Number (Percentage)	
	Primary diagnosis	*Secondary diagnosis*
Anxiety	39 (38.2%)	43 (42.2%)
Depression	36 (35.3%)	41 (40.2%)
Schizophrenia	13 (12.7%)	1 (1.0%)
Personality disorder	3 (2.9%)	0
Loneliness	3 (2.9%)	9 (8.8%)
PTSD	2 (2.0%)	0
Paranoid schizophrenia	2 (2.0%)	0
OCD	1 (1.0%)	1 (1.0%)
Parkinson's disease	1 (1.0%)	0
Dementia	1 (1.0%)	0
Psychosis	1 (1.0%)	2 (2.0%)
Self-esteem	0	4 (3.9%)
Agoraphobia	0	1 (1.0%)

Table 3. Levels of wellbeing.

Level of mental wellbeing according to mean SWEMWBS scores in England	Number of participants (percentage) at baseline	Number of participants (percentage) at follow-up
Low (below 19.3)	91 (89.2%)	44 (43.1%)
Normal (19.3 - 28.1)	11 (10.8%)	56 (54.9%)
High (above 28.1)	0	2 (2.0%)

3.2. Analysis

3.2.1. Paired T-Tests for the Whole Sample

SWEMWBS scores significantly improved ($p < 0.001$) by 5.52 points ($SD = 4.05$) from baseline to follow-up, with a very large effect size (Cohen's d = −1.36).

3.2.2. T-Tests for Males/Females

SWEMWBS scores significantly improved in females (n = 74; $p < 0.001$) by 5.53 points ($SD = 3.07$) from baseline to follow-up, with a very large effect size (Cohen's d = −1.49). SWEMWBS scores significantly improved in males (n = 28; $p < 0.001$) by 5.54 points ($SD = 4.93$) from baseline to follow-up, with a very large effect size (Cohen's d = −1.49).

3.2.3. T-Tests for Ages

SWEMWBS scores significantly improved in participants aged 18 - 36 years (n = 21; $p < 0.001$) by 5.05 points ($SD = 2.20$) from baseline to follow-up, with an extremely large effect size (Cohen's d = −2.29). SWEMWBS scores significantly improved in participants aged 37 - 55 years (n = 4; $p < 0.001$) by 6.07 points ($SD =$

4.17) from baseline to follow-up, with a very large effect size (Cohen's d = −1.46). SWEMWBS scores significantly improved in participants aged 56+ years (n = 40; $p < 0.001$) by 5.23 points ($SD = 4.66$) from baseline to follow-up, with a very large effect size (Cohen's d = −1.12).

3.2.4. T-Tests for Primary Diagnosis

SWEMWBS scores significantly improved in participants with a primary diagnosis of depression (n = 36; $p < 0.001$) by 5.28 points ($SD = 3.76$) from baseline to follow-up, with a very large effect size (Cohen's d = −1.40). SWEMWBS scores significantly improved in participants with a primary diagnosis of anxiety (n = 39; $p < 0.001$) by 5.44 points ($SD = 4.14$) from baseline to follow-up, with a very large effect size (Cohen's d = −1.31). SWEMWBS scores significantly improved in participants with a primary diagnosis of schizophrenia (n = 15; $p < 0.001$) by 6.60 points ($SD = 3.79$) from baseline to follow-up, with a very large effect size (Cohen's d = −1.74).

3.2.5. T-Tests for Ethnicity

SWEMWBS scores significantly improved in participants identifying as White British (n = 77; $p < 0.001$) by 5.47 points ($SD = 4.07$) from baseline to follow-up, with a very large effect size (Cohen's d = −1.65). SWEMWBS scores significantly improved in participants identifying as non-White British (n = 2; $p < 0.001$) by 5.72 points ($SD = 4.08$) from baseline to follow-up, with a very large effect size (Cohen's d = −1.95).

4. Discussion

This study investigated the impact of Hospital at Home on psychological wellbeing. Hospital at Home has been successfully delivered, providing evidence of feasibility and acceptability. The findings showed that participants can benefit from Hospital at Home in terms of improving their psychological well-being. Wellbeing improved irrespective of gender, age, ethnicity, or primary diagnosis. Participant improvements on the SWEMWBS measure indicate a positive impact of Hospital at Home on individuals' wellbeing, subjective happiness, life satisfaction, self-realisation, and psychological functioning. These are all factors that are important for quality of life, coping, mental health recovery, and thriving. The results strengthen the argument for the necessity of effective transition support for return to the community following a mental health hospital admission (Gerson & Rose, 2012; Griffiths et al., 2015; Tyler et al., 2019; Vigod et al., 2013).

Mental health recovery is a heterogeneous process with wide variation between individuals (Davidson, 2016). The identification of personal goals of people using the service and the targeting of support in specific areas and supporting individual needs, with the resulting improvement in wellbeing, indicates the value of the approach applied by Hospital at Home. The results indicate the value of Hospital at Home's individualised approach, providing goal-setting, progress monitoring, structure, and support; this adds to existing evidence of this approach (Pedley et al.,

2018). Hospital at Home findings support previous evidence showing the importance of educational and relational elements (Nunes et al., 2025).

A key aspect of Hospital at Home is building relationships with community-based services, groups, organisations, and resources; such networks can help reduce re-admission rates and improve quality of life for people who return to the community (Forchuk et al., 2005). Hospital at Home has post-discharge and community bridging components that Vigod et al.'s (2013) review found may reduce early psychiatric hospital readmission. Hospital at Home applies the NICE (2011) guidance by providing person-centred support that takes into account service users' needs, goals, preferences, and strengths. The service successfully applies a strengths and mental health recovery-based model of community care (Davidson, 2016).

Previous research demonstrates the issue of heterogeneity in transition from hospital to community interventions (Tyler et al., 2019): Hospital at Home is an example of how a structured programme can be implemented into an NHS trust, indicating the possibility of implementing Hospital at Home in other NHS trusts across the UK. A future Randomised Controlled Trial (RCT) involving multiple NHS trusts testing Hospital at Home is justified in order to validate the results seen in the current study.

Study limitations include the lack of a control group. This is an initial study to understand feasibility and recruitment issues to support further research that would incorporate a control group. A confounding factor is that the participants would have been registered with a Community Mental Health Team (CMHT) services during the intervention, and they may have provided support and treatment. The amount of support and treatment from CMHT was not controlled for; effective support and treatment from CMHT during the time of the study would have positively impacted results. However, CMHT input is very limited due to the very high caseload of CMHT mental health nurses, and many participants will have had no or very little input during the period of the project. In this study, females were overrepresented, so the results are less relevant to males. The majority identified as "White British", so this research is less relevant to other ethnic groups. Participants were assessed immediately after the end of the intervention; therefore, only short-term outcomes could be reported. All participants were under the care of one English county-based NHS trust (in a single geographical and socioeconomic area), limiting the generalisability of the results to other areas. However, all NHS trusts provide similar inpatient and CMHT services.

5. Conclusion

Hospital at Home has a positive impact on wellbeing after just two weeks. In future research, an appropriately powered multi-site RCT with longer-term follow-up to investigate efficacy could provide further evidence for roll-out. Improved wellbeing is a key aim of community-based mental health services. There is a lack of effective transition interventions available following discharge from mental

health hospitals. These results show that participants can benefit from this individualised and low-cost intervention that meets the requirements of mental health service delivery goals. These outcomes support the delivery of Hospital at Home and its implementation across the NHS and beyond.

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Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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