Preventing Poor Mental Health in Havering

Chapter Summary

Levels of Prevention

Primary
Promote good mental health before symptoms appear

Secondary
Early detection & intervention to reduce progression

Tertiary
Manage established conditions to reduce long-term impact

Prevention in Havering

Key local interventions

- Community Institutions. like Havering Adult College and pastoral care teams in schools and colleges
- Voluntary and Community Organisations, like Mind, AgeUK, Andy's Man Club
- Cross-Sector Support, like social prescribers, care navigators, local area coordinators

What the Evidence Tells us:

Housing support & welfare advice are critical foundations for good mental health; Housing First reduces emergency service use

Self-management approaches are supported by this literature review in being effective for individuals with diagnosed severe mental illness

Recovery Colleges help all levels of prevention, build skills, reduce isolation, promote engagement, not just for diagnosed individuals

Primary prevention delivers intergenerational benefits—supporting adult mental health while improving outcomes for children and young people

Havering
LONDON BOROUGH

Adult Mental Health Needs Assessment 2025

Preventing Poor Mental Health and Mental Health Crises in Havering Chapter

Contents

Preventing mental health crises in adults

Key findings and Implications for Practice

- Evidence supports interventions to address the underlying building blocks for good mental health—such as housing support and social welfare advice—although the links to reducing mental health crisis are less well established.
- Voluntary and community sector organisations are well-positioned to deliver preventative interventions.
- Self-management approaches, recommended by NICE, are supported by this literature review in being effective for individuals with diagnosed severe mental illness.
- Recovery Colleges can support prevention at all levels—not just for those with diagnosed conditions—by reducing isolation, building skills and improving engagement.
- There are opportunities to explore local learning from other boroughs and neighbouring trusts—such as Recovery Colleges in Waltham Forest and Tower Hamlets and the money advice pilot in East London Foundation Trust (ELFT).
- Evidence supports housing interventions, including Housing First, for reducing emergency mental health service use. Havering's use of this model should continue and other opportunities to address housing concerns before people reach mental health crisis should be explored.
- Focused and additional support for high-risk groups is shown to help prevent escalation to crisis. In Havering, this targeted support should be strengthened using existing models, such as social prescribing and Local Area Coordinators.
- Limited evidence exists for primary prevention of mental health crisis, particularly in the UK context.
- Emerging models, such as crisis cafés, must undergo evaluations to understand their full impact on service users and outcomes, including unintended consequences.
- Primary prevention could help reduce the onset of mental health problems and have broader intergenerational benefits. Supporting good adult mental health has additional benefits for children and young people's mental health.
- Children of people with severe mental illness are a vulnerable group who could benefit from targeted, early intervention efforts.

Recommendations

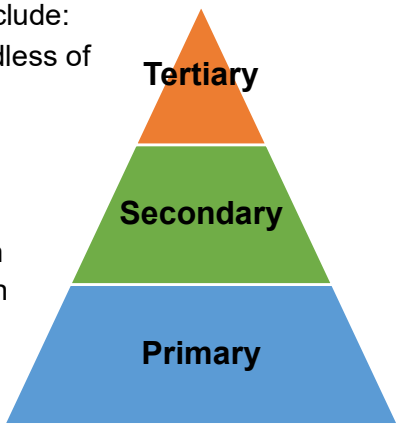
- Front-line services to utilise support, such as Local Area Coordinators and social prescribing, for people at higher risk.
- Support and evaluate crisis café, considering unintended consequences on service users and outcomes.
- Continue information sharing with other NEL boroughs, for example with proposed community MH improvement network and effectiveness of Crisis House models.
- Explore local learning from other boroughs and neighbouring trusts – such as Recovery Colleges in Waltham Forest and Tower Hamlets, and co-located financial advice pilot in ELFT.
- LBH to continue to secure funding for Housing First approach. Explore opportunities to address housing concerns before people reach a mental health crisis point.

Prevention in adult mental health

As described in the *Risks, Causes and Impacts* chapter, the development of poor mental health is a complex and multifaceted process, shaped by a range of risk factors. Preventative measures aim to reduce the incidence, prevalence, and recurrence of mental health disorders and their associated impacts. These interventions typically focus on reducing exposure to risk and strengthening individual resilience and coping mechanisms.[1]

Prevention can be classified into three categories:

1. **Primary prevention:** Aims to promote good mental health and prevent the onset of a mental health conditions before symptoms appear. This may include:
    - Universal prevention: Targeting the entire population, regardless of individual risk.
    - Selective prevention: Focusing on subgroups at higher risk.
    - Indicated prevention: Supporting individuals showing early, subthreshold clinical symptoms.[2]
2. **Secondary prevention**: Seeks to identify and intervene early in the course of a mental health condition to reduce its progression once symptoms have begun.
3. **Tertiary prevention:** Involves managing established mental health conditions to manage or reduce the impact.



Prevention in Havering

In England, including London, public mental health interventions tend to address a limited number of risk and protective factors, primarily focused on individuals and their immediate social environment.[3] Few interventions take a broader approach to the wider determinants of mental health—such as housing, employment, financial security and family dynamics—which are critical to long-term mental wellbeing.

In Havering, a range of interventions are provided by the health, statutory and community sectors, including:

- **Community institutions**, such as Havering Adult College and pastoral care teams in schools and colleges, which promote mental well-being through education and supportive environments.
- **Voluntary and community organisations**, including Mind, AgeUK and Andy's Man Club, which offer targeted support.
- **Social prescribers, care navigators and local area coordinators**, who work across sectors to address individuals' holistic needs and support early intervention.

[1] Arango, C., Díaz-Caneja, C. M., McGorry, P. et al (2018). Preventive strategies for mental health. The Lancet Psychiatry, 5(7), 591–604. https://doi.org/10.1016/S2215-0366(18)30057-9
[2] Arango et al, (2018)
[3] Duncan, F., Baskin, C., McGrath, M., et al (2021). Community interventions for improving adult mental health: mapping local policy and practice in England. BMC Public Health, 21(1), 1691. https://doi.org/10.1186/s12889-021-11741-5

Evidence Review: preventing mental health crises in Havering adults

Introduction

The Adult Mental Health Needs Assessment (AMHNA) working group identified early intervention to prevent individuals from reaching a mental health crisis as a key priority, driven by growing concerns about increasing pressure on acute and crisis care pathways. In collaboration with North East London Foundation Trust (NELFT) Library Services, a literature review was conducted to explore the effectiveness of community-based interventions in reducing emergency service presentations related to mental health crises.

A range of services currently provide urgent care for individuals experiencing a mental health crisis. These are often designed to prevent inpatient admission, which is both costly and "often associated with poor patient experience, and potential harms including loss of rights and freedoms, stigma, institutionalisation and development of unhelpful coping strategies".[4]

There is also growing recognition that emergency departments may not be appropriate environments for those in mental health crisis. The NHS Long Term Plan identified alternatives, such as crisis sanctuaries and crisis cafes, as more suitable options than A&E for many people in crisis.[5] Crisis cafes, in particular, are community-based, non-clinical services offering non-clinical therapeutic and social support in a welcoming, informal setting, often available out of hours.

At the time of writing, Havering is in the process of establishing a crisis café in partnership with a voluntary sector partner. There is also increasing interest in identifying and investing in preventive interventions—those that support individuals before they reach a crisis point. These preventative approaches are the central focus of this review.

Methods

The NELFT Library Service conducted a database search for papers from 2004 to 2024, on community-based interventions targeting individuals, groups or wider communities, including psychosocial interventions, to reduce mental health presentations to emergency services. For full details of the search strategy, see Appendix A.

PICOS Framework

- **Population:** People aged 18+, with or without an existing mental health clinical diagnosis
- **Intervention:** Community-based interventions targeting individuals, groups or wider communities, including psychosocial interventions.
- **Comparison:** Usual care
- **Outcomes:**
    - Reduction in mental health presentations to emergency services (emergency services includes both Emergency Department (ED) visits and 999/111 calls)
    - Patient-rated experience and satisfaction
    - Cost-effectiveness of interventions

[4] Foye, U., Appleton, R., Nyikavaranda, P. et al (2023). 'Beyond places of safety' – a qualitative study exploring the implementation of mental health crisis care innovations across England. BMC Health Services Research, 23(1), 1106. https://doi.org/10.1186/s12913-023-10058-w
[5] NHS Long Term Plan, 2019, https://www.longtermplan.nhs.uk/online-version/chapter-3-further-progress-on-care-quality-and-outcomes/better-care-for-major-health-conditions/adult-mental-health-services

    - Mental health and wellbeing outcomes (e.g., PHQ-9; GAD-7; WSAS); Mental Health Act admissions)

- **Study types**: included systematic reviews, peer-reviewed primary research and relevant grey literature. Excluded were editorials, commentaries and case studies.

After an initial screening by the library specialist, two reviewers independently screened titles and abstracts of 108 papers, resulting in 36 for full-text screening. An additional 16 papers for full-text screening were identified through citation tracking and knowledge of the field, including an additional 8 on Recovery Colleges. Of the total 52 full-text articles reviewed, 24 were included in this review.

Grey literature including NICE[6] guidance, NHS Long Term Plan and relevant professional bodies' reports were also reviewed.

The most common reasons for exclusion were:

- Focus on health service interventions such as Crisis Response Teams
- Inappropriate population
- Lack of relevant outcomes (i.e., emergency health service use)
- Full texts were not available for two papers.

Results

Meta analyses and systematic reviews	Other reviews	Primary research	Modelling studies	Other
5	6	7	2	4

Few papers focused explicitly on primary prevention. Preventative interventions that address the building blocks of good mental health, such as providing financial and housing support, were explored in a small number of primary research studies. Most literature explored interventions targeted for individuals with existing mental health diagnoses (e.g., preventing relapse in people with severe mental illness).

Primary prevention

One article found in the search, from the *Lancet Psychiatry,* explored primary prevention of mental health conditions.[7] It focused on universal, whole-population interventions during infancy, childhood and adolescence—especially the prenatal and perinatal periods—as crucial windows for preventing the onset of mental health problems. These interventions, however, fall outside the scope of this review, which focuses on adult populations.

However, the authors identify the children of people with severe mental illness (SMI) as a potential cohort for selective preventative interventions. Indicated preventive interventions – those targeted at individuals at high risk or with early, subclinical signs rather than the whole population – can shift expected trajectories towards less debilitating outcomes and are potentially more cost-effective as they minimise the number of people requiring the intervention.

[6] National Institute for Health and Care Excellence
[7] Arango et al, (2018)

Examples include providing cognitive behavioural therapy (CBT) to individuals at high risk of psychosis or early intervention to prevent chronic post-traumatic stress disorder (PTSD) in patients following traumatic events.

In Paton et al's 2016 UK review on the effectiveness of interventions on the crisis pathway, they found minimal evidence supporting preventative approaches delivered before crisis:[8]

- No robust evidence on the interface between primary and secondary care for crisis prevention.
- No convincing evidence that training healthcare professionals improved outcomes for people who self-harm.
- No evidence for early *detection* of psychosis programmes in reducing the duration of psychosis, although they do change referral patterns.

The authors rated evidence in these areas to be low quality with high risk of bias.

Alternatively, another review found by the literature search identified a U.S. study that demonstrated that early identification of psychosis—via education for school counsellors and community staff – demonstrated that population-wide early identification is feasible and that preventative intervention are linked to reduced rates of first-episode hospitalisations for psychosis.[9] However, this intervention was implemented in the early 2000s and may not be directly transferable to a UK context; the Paton et al review offers a more comprehensive analysis.

Financial support

An intervention in Liverpool, in which healthcare professionals can refer individuals to a *Citizen's Advice on Prescription* service, was associated with:

- Reduced A&E attendances
- Reduced mental health-related GP consultations
- Fewer antidepressant prescriptions
- Fewer mental health emergencies.[10]

The estimated NHS saving was £91 per person (95% CI £44-£107). The NHS-funded programme provided rapid access to resources for financial, housing, domestic abuse, fuel poverty and social isolation, as well as signposting to local wellbeing services.

These findings align with a systematic review of community interventions for promoting the supporting working-age adults experiencing financial uncertainty, which found some evidence that such interventions could influence financial insecurity and associated mental health problems, such as group job skills training, and the provision of legal and welfare advice in primary care.[11]

The East London Foundation Trust evaluated a money advice service embedded within a paediatric neuro-disability clinic and found that supported families were able to access an average of more than £6000 in increased benefits, reporting a positive impact on their

[8] Paton F, Wright K, Ayre N, et al. (2016) Improving outcomes for people in mental health crisis: a rapid synthesis of the evidence for available models of care. Health Technol Assess ;20(3). https://doi.org/10.3310/hta20030
[9] McFarlane, W. R., Susser, E., McCleary, R., et al (2014). Reduction in Incidence of Hospitalizations for Psychotic Episodes Through Early Identification and Intervention. Psychiatric Services, 65(10), 1194–1200. https://doi.org/10.1176/appi.ps.201300336
[10] Aregawi, G., Roberta, P., Konstantinos, D et al (2025). The impacts of Liverpool Citizen's Advice on Prescription (CAP) on mental health outcomes– an Instrumental Variable (IV) approach, *Population Health*, https://doi.org/https://doi.org/10.1016/j.ssmph.2025.101785
[11] McGrath, M., Duncan, F., Dotsikas, K et al. (2021). Effectiveness of community interventions for protecting and promoting the mental health of working-age adults experiencing financial uncertainty: a systematic review. Journal of Epidemiology and Community Health, 75(7). https://doi.org/10.1136/jech-2020-215574

mental wellbeing.[12] Thought not peer-reviewed and not focused on emergency health service use, the model draws on similar initiatives in Australia.[13]

Housing Support

A systematic review of psychosocial interventions for patients with mental illness who are experiencing homelessness suggest that housing support and case management are effective measures to address the issues of mental ill health in this cohort.[14] However, no UK studies were included.

Another scoping review on reducing emergency department (ED) use among people experiencing homelessness with mental health issues found:[15]

- Most (6 of 9) found fewer ED visits among the intervention group
- 7 out of 8 studies that assessed hospitalisations noted fewer hospital admissions and/or hospital inpatient days

Again, no UK-based evidence was identified.

A review of evidence for psychosocial interventions for reducing compulsory admissions (i.e., admissions under the Mental Health Act) found no randomised controlled trials assessing the impact of housing or employment-related interventions.[16]

Social isolation

No studies were identified that directly assessed the impact of social isolation or loneliness interventions on crisis prevention. However, Duncan et al's analysis of public mental health interventions in England found that such interventions—such as social activities or befriending—were among the most common public mental health interventions.[17]

Role of the voluntary sector

A review of the voluntary sector's contribution to mental health crisis care identified gaps in prevention:

- Limited availability of psychotherapeutic options for people to address their underlying difficulties, even when immediate crisis support was available. For example, voluntary sector organisations, along with Recovery Colleges, may offer programmes to enable people to address their difficulties and develop strategies for coping, but these were not factored into individuals' crisis planning.

[12] UK Prevention Research Partnership, 2024, Healthier, wealthier families: Money advice services in trusted community settings https://www.elft.nhs.uk/sites/default/files/2024-12/Healthier%20wealthier%20families%20policy%20briefing.pdf Accessed 01 May 2025
[13] Price, A. M. H., White, N., Burley, J., et al (2023). Feasibility of linking universal child and family healthcare and financial counselling: findings from the Australian Healthier Wealthier Families (HWF) mixed-methods study. BMJ Open, 13(11). https://doi.org/10.1136/bmjopen-2023-075651
[14] Roy, R, Janaki, Aravind et al. (2024). Outcomes of psychosocial interventions for homeless individuals with mental illness: A systematic review. International Journal of Social Psychiatry, 70(5), 841–849. https://doi.org/10.1177/00207640231217173
[15] Davis, R. A., Lookabaugh, M., Christnacht, K., & Stegman, R. (2024). Strategies to Reduce Frequent Emergency Department Use among Persons Experiencing Homelessness with Mental Health Conditions: a Scoping Review. Journal of Urban Health, 101(5), 968–978. https://doi.org/10.1007/s11524-024-00917-0
[16] Bone, J. K., McCloud, T., Scott, H. R., et al (2019). Psychosocial Interventions to Reduce Compulsory Psychiatric Admissions: A Rapid Evidence Synthesis. EClinicalMedicine, 10, 58–67. https://doi.org/https://doi.org/10.1016/j.eclinm.2019.03.017
[17] Duncan et al, (2021)

- Insufficient commissioning of voluntary sector organisations for prevention work, despite their demonstrated strengths in providing these services.[18]

Secondary Prevention and Preventing Relapse

Individuals with psychotic and bipolar disorders comprise a disproportionate number of mental health-related attendances at Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) emergency departments (see *Service Provision and Service Demand* chapter). Interventions to prevent relapse in this cohort of patients could reduce the pressures on the crisis pathway.

NICE recommends a number of interventions to support recovery and prevent relapse, including:[19]

- Self-management, which encompasses various interventions that commonly involve the provision of information and education on a condition and its treatment, developing skills for self-monitoring symptoms, and strategies to support adherence to treatment including medication, psychological techniques, lifestyle and social support.[20]
- Supported employment to improve independence and quality of life.

These interventions may be delivered through the NHS, the voluntary sector or peer-led models.

A 2023 scoping review of 16 studies (mainly US-based) examining interventions to prevent recurrent ED attendances among patients with a mental health diagnosis found that crisis planning and self-management interventions with a relapse prevention element are most promising for preventing attendances.[21] However, the authors noted many of the included studies were small and/or underpowered.

A systematic review of self-management programmes for people with severe mental illness (SMI) found they had a significant reduction in hospital length of stay, although evidence on relapse and readmission was inconsistent.[22]

An observational study using administrative data in the US found that peer support decreased the likelihood of psychiatric hospitalisation compared to a control group of community mental health services without peer support.[23]

Another US-based study of a group-based behavioural skills training intervention showed short-term (but not long-term) efficacy in reducing emergency psychiatric service use, for middle-aged and older patients with chronic psychotic disorders.[24]

Caregiver Interventions

[18] Newbigging K, Rees J, Ince R, et al. The contribution of the voluntary sector to mental health crisis care: a mixed-methods study. Health Serv Deliv Res. 2020;8(29).
[19] Paton et al, 2018
[20] Lean, M., Fornells-Ambrojo, M., Milton, A., et al (2019). Self-management interventions for people with severe mental illness: systematic review and meta-analysis. British Journal of Psychiatry, 214(5), 260–268. https://doi.org/10.1192/bjp.2019.54
[21] Mao, W., Shalaby, R., & Agyapong, V. I. (2023). Interventions to Reduce Repeat Presentations to Hospital Emergency Departments for Mental Health Concerns: A Scoping Review of the Literature. Healthcare. https://doi.org/10.3390/healthcare11081161
[22] Lean et al, 2019
[23] Landers, G.M., Zhou, M. An Analysis of Relationships Among Peer Support, Psychiatric Hospitalization, and Crisis Stabilization. *Community Ment Health J* **47**, 106–112 (2011). https://doi.org/10.1007/s10597-009-9218-3
[24] Mausbach, BT, Cardenas, V, McKibbin, C.L et al, (2008) Reducing emergency medical service use in patients with chronic psychotic disorders: Results from the FAST intervention study, Behaviour Research and Therapy, 46(1), https://doi.org/10.1016/j.brat.2007.10.001

Two studies examined psychosocial interventions targeted at caregivers of individuals with schizophrenia.[25,26] These interventions—such as psychoeducation, family therapy, and behavioural interventions—can be delivered through health services or community organisations.

Ashcroft et al's 2018 meta-analysis found caregiver-directed interventions significantly reduced hospital admissions and relapse compared to treatment as usual, particularly within the first 12 months of follow-up.[27] However, the effect on ED admissions was not statistically significant.

This builds on findings from an earlier Cochrane review, which suggested family psychoeducation for patients with schizophrenia may reduce hospital admissions at 12 and 18 months. However, the Cochrane authors noted about methodological quality, which may have inflated the reported benefits.[28]

Community care networks

A long-term Dutch study looked at community care networks – partnerships between local police, housing, social services and mental healthcare services – comparing mental healthcare use in neighbourhoods with and without these networks (from 1992-2001).[29] The coordinated approach focused on detection and prevention rather than on supporting patients already in contact with specialist services. The study found:

- Increased use of emergency psychiatric services, likely due to early detection and referrals.
- Decreased psychiatric hospital admissions, possibly from improved health and social functioning under network supervision.
- Reduced involuntary admissions, potentially resulting from early involvement of emergency services and community support.

Recovery College

Recovery Colleges (RCs) are a community-based educational model for people both with and without mental health challenges, co-produced by people with lived experience and professionals.[30] First piloted in South London in 2009, RCs now operate widely across England and internationally; most in England are open to the public who may have no connection to mental health services, targeting all levels of prevention.[31]

Research indicates RC participation may reduce hospital bed days, admissions (including for those under the Mental Health Act), and use of community mental health services. For example:

[25] Ashcroft, K., Kim, E., Elefant, E., Benson, C., & Carter, J. A. (2018). Meta-Analysis of Caregiver-Directed Psychosocial Interventions for Schizophrenia. Community Mental Health Journal, 54(7), 983–991. https://doi.org/10.1007/s10597-018-0289-x
[26] Pharoah, F., Mari, J. J., Rathbone, J., & Wong, W. (2010). Family intervention for schizophrenia. Cochrane Database of Systematic Reviews, (12). https://doi.org/10.1002/14651858.CD000088.pub3
[27] Ashcroft et al (2018)
[28] Pharoah et al (2010)
[29] Wierdsma, A. I., Poodt, H. D., & Mulder, C. L. (2007). Effects of community-care networks on psychiatric emergency contacts, hospitalisation and involuntary admission. Journal of Epidemiology and Community Health, 61(7), https://doi.org/10.1136/jech.2005.044974
[30] Perkins, R., Meddings, S., Williams, S. & Repper, J. (2017) Recovery Colleges 10 years on. IMROC, https://www.imroc.org/publications/recovery-colleges-10-years-on (Accessed 14 May 2025)
[31] Hayes, D., Camacho, E. M., Ronaldson, A., et al (2024). Evidence-based Recovery Colleges: developing a typology based on organisational characteristics, fidelity and funding. Social Psychiatry and Psychiatric Epidemiology, 59(5), 759–768. https://doi.org/10.1007/s00127-023-02452-w

- In Sussex, students who completed a course had fewer hospital bed days, fewer admissions and fewer admissions under section and reduced community contacts.[32]
- Kay and Edgeley reported that two-thirds of RC students using secondary mental health services showed a reduction in service use after attending the college, which they estimated could lead to annual cost savings of £1,000 to £2,000 per student.[33]

However, retrospective research designs and current lack of randomised controlled data limits the strength of conclusions about the impact of Recovery Colleges.[34]

Borderline personality disorder crisis service

One study identified focused on emergency service use among people with borderline personality disorder (BPD). It evaluated a redesigned NHS service that created a dedicated case management team and a combined day treatment and crisis service for patients who are too dysregulated to access typical office-based psychotherapy, using funding earmarked for out-of-area treatment.[35]

Findings showed a short-term increase in urgent care use, which later stabilised. Over time, both hospitalisations and out-of-area placements declined. While the intervention appeared cost saving, the study was observational, had a small sample size and did not include other health or care costs.

Cost Effectiveness Evidence

Evidence on cost-effectiveness relevant to the English context remains limited. One economic modelling study found preventative interventions might be cost effective, including:

- Debt management
- Early detection of psychosis (for patients with prodromal symptoms)
- Workplace screening for depression and anxiety[36]

However, the study likely underestimates economic benefits due to modelling limitations. The authors highlight that an important characteristic of mental ill health is its wide ranging effects in many different areas of an individual's life. Furthermore, it is from 2011 so the underlying costs used in its modelling likely do not reflect current conditions.

Modelling studies

An Australian study modelled the effect of interventions to reduce mental health emergency department visits among young people aged 15-24 through interventions such as:

- A crisis response programme in which a mental health professional travels with the ambulance services
- Universal suicide risk screening

[32] Bourne, P., Sara, M., & and Whittington, A. (2018). An evaluation of service use outcomes in a Recovery College. Journal of Mental Health, 27(4), 359–366. https://doi.org/10.1080/09638237.2017.1417557
[33] Thériault, J., Lord, M.-M., Briand, C., et al (2020). Recovery Colleges After a Decade of Research: A Literature Review. Psychiatric Services, 71(9), 928–940. https://doi.org/10.1176/appi.ps.201900352
[34] Hayes et al, Evidence-based Recovery Colleges, 2024
[35] Graham, S., Gardner, K., Sebalo, I., et al (2024). Designing Community Services for People With Borderline Personality Disorder to Reduce Hospitalizations. Psychiatric Services, 75(5), https://doi.org/10.1176/appi.ps.20230028
[36] Knapp, M., McDaid D & Parsonage, M. (2011). Mental health promotion and mental illness prevention: The economic case, LSE https://eprints.lse.ac.uk/39300/1/Mental_health_promotion_and_mental_illness_prevention(author).pdf

- Active telephone outreach after discharge[37]

As the findings are from a modelling study, it cannot comment on the real-world effect of the intervention and may not translate to the UK setting or Havering-specific needs.

Discussion

This review explored community-based interventions aimed at reducing the development of mental health crises and their impact on emergency health service use. This review has identified a limited number of interventions targeting the wider determinants of good mental health—such as housing support and access to financial advice—which may help people avoid crises and remain well.

This aligns with evidence from other studies, which found high-intensity interventions aimed at improving employment (Individual Placement and Support) can positively affect the social circumstances of people with mental health conditions, but links to health service use are less clear.[38] Similarly, Barnett et al's review found limited evidence on the effects of reducing social isolation, although this is known to be an important driver of poor mental health.

Self-management interventions—recommended by NICE and found in the literature search—show promising outcomes, particularly for people with SMI. Caregiver-focused interventions may also help prevent relapse in psychotic disorders and can be delivered through both statutory services and the voluntary sector.

Recovery Colleges offer a flexible model for delivering self-management interventions, spanning primary to tertiary prevention. Evidence suggests that RCs are associated with reduced healthcare use, while also addressing social isolation, stigma and educational and vocational barriers. Local RC examples from both Waltham Forest and Tower Hamlets could offer valuable insights for Havering.

Improved collaboration between services, such as the community care networks in Rotterdam, show that this can help reduce psychiatric hospitalisations.

There is limited robust evidence to support primary prevention crisis interventions, supporting the findings of an earlier review which found very little evidence on the effectiveness of services provided before crisis in the UK.[39] Two studies highlight that preventative interventions may paradoxically increase emergency department use, especially in the short-term, due to earlier identification and increased help seeking, although the impact of this may be countered by reduced hospital admissions.[40] This highlights the importance of evaluating emerging models and considering unintended consequences and potential harms.[41]

Conducting robust research in mental health remains challenging, as many studies suffer from small sample sizes, short follow-up periods or an inability to establish causality. Much of the evidence is derived from non-UK contexts, limiting its applicability to England's. Cost-

[37] Vacher, C., Ho, N., Skinner, A. et al. Reducing mental health emergency visits: population-level strategies from participatory modelling. BMC Psychiatry 24, 627 (2024). https://doi.org/10.1186/s12888-024-06066-7
[38] Barnett, P., Steare, T., Dedat, Z et al (2022). Interventions to improve social circumstances of people with mental health conditions: a rapid evidence synthesis. BMC Psychiatry, 22(1), 302. https://doi.org/10.1186/s12888-022-03864-9
[39] Paton et al, (2016)
[40] Wierdsma et al, (2007); Graham et al (2024)
[41] Foye et al, (2023)

effectiveness studies within the UK is particularly limited, with no included studies providing full economic evaluations.

Overall, the literature is more developed in relation to preventing relapse among individuals with diagnosed SMI than in preventing the initial onset of mental health conditions. Most evidence also relates to services delivered within inpatient or community mental health settings (which is outside the scope of this review), rather than broader, community-level interventions.

There is no single, definitive intervention to reduce mental health-related emergency service use, which reflects the multifaceted risk factors underlying the development of mental health problems and the complexity of mental health crisis.[42] However, interventions that address the building blocks of good mental health – such as secure housing, adequate income and social connectedness—may contribute to preventing the development of mental health crises and support people to stay well.

Limitations

This review has several limitations. Due to resource constraints, initial screening was conducted by the library service, which may have resulted in the exclusion of relevant studies. Existing research highlights a gap in the evidence for interventions addressing known determinants of mental ill health, such as debt and social isolation.[43] The focus of this review was on reducing mental health emergency service use, which limited eligible papers, as there is wider reporting on improvements in mental health outcomes, such as self-reported wellbeing, rather than emergency health service use. Furthermore, interventions to reduce mental health issues that do not reach the threshold for crisis or emergency department use were not considered in this review. This review did not cover all at-risk populations, such as those with perinatal mental health needs, which could be a valuable focus for future work.

Acknowledgements

Thanks to Stephen Reid, NELFT Library and Knowledge Service, for support with the evidence search: [PH Bulletin] Interventions to reduce mental health crises SN55137. Stephen Reid. 13th January, 2025. London, UK: NELFT Library and Knowledge Service.

Appendices

Appendix A

Search strategy

Embase <1974 to 2025 January 03>
Ovid MEDLINE(R) ALL <1946 to January 03, 2025>

1 mental health.ti,kw. 239981
2 *Mental Health/ 106151

[42] Paton et al, (2016)
[43] Barnett, P., Steare, T., Dedat, Z. *et al.* Interventions to improve social circumstances of people with mental health conditions: a rapid evidence synthesis. *BMC Psychiatry* **22**, 302 (2022). https://doi.org/10.1186/s12888-022-03864-9

3 mental disorder*.ti,kw. 41793
4 *Mental Disorders/ 205101
5 mental illness*.ti,kw. 36055
6 personality disorder*.ti,kw. 28846
7 exp *Personality Disorders/ 65889
8 (psychosis or psychotic).ti,kw. 90840
9 *Psychotic Disorders/ 74851
10 schizophrenia.ti,kw. 212927
11 exp *Schizophrenia/ 232430
12 anxiety.ti,kw. 227562
13 *Anxiety Disorders/ 39945
14 depress*.ti,kw. 543820
15 exp *Depressive Disorder/ 397721
16 *Depression/ 297780
17 psychiatric.ti,kw. 163014
18 or/1-17 1715146
19 ((decreas* or prevent* or reduc*) adj6 (crisis or crises or admission* or readmission* or hospitalis* or hospitaliz* or emergency or ED)).tw. 187711
20 (decreas* or prevent* or reduc*).ti,kw. and (emergency service, hospital/ or emergency services, psychiatric/ or hospitalization/ or patient admission/ or Commitment of Mentally Ill/) 43237
21 19 or 20 216553
22 intervention*.tw. 3592421
23 Crisis Intervention/ 13372
24 22 or 23 3600288
25 18 and 21 and 24 3365
26 (adolescent/ or exp child/ or exp infant/) not exp adult/ 4876761
27 25 not 26 3077
28 27 use medall 1246
29 mental health.ti,kw. 239981
30 *mental health/ 106151
31 mental disorder*.ti,kw. 41793
32 *mental disease/ 124299 33 mental illness*.ti,kw. 36055 34 personality disorder*.ti,kw. 28846 35 exp *personality disorder/ 65889 36 (psychosis or psychotic).ti,kw. 90840 37 *psychosis/ 97363 38 schizophrenia.ti,kw. 212927 39 exp *schizophrenia/ 232430 40 anxiety.ti,kw. 227562
41 exp *anxiety disorder/ 209843
42 depress*.ti,kw. 543820
43 exp *depression/ 391215
44 psychiatric.ti,kw. 163014
45 or/29-44 1777391
46 ((decreas* or prevent* or reduc*) adj6 (crisis or crises or admission* or readmission* or hospitalis* or hospitaliz* or emergency or ED)).tw. 187711
47 (decreas* or prevent* or reduc*).ti,kw. and (emergency health service/ or exp psychiatric emergency service/ or hospitalization/ or hospital admission/ or involuntary commitment/) 43633
48 46 or 47 217951
49 intervention*.tw. 3592421
50 crisis intervention/ or intervention study/ or early intervention/ or psychosocial intervention/ 666905
51 49 or 50 4123717
52 45 and 48 and 51 3479
53 (juvenile/ or exp adolescent/ or exp child/) not exp adult/ 4368163
54 52 not 53 3183
55 54 use oemezd 1989
56 28 or 55 3235
57 remove duplicates from 56 2249
58 57 not (conference abstract or letter or editorial or note).pt. 1782
59 limit 58 to english language 1665
60 limit 59 to yr="2004 -Current" 1481

Databases:
APA PsycInfo®

S1 (TI,IF("mental health" OR "mental disorder*" or "mental illness*" or psychiatric)) OR (MJSUB.EXACT("Mental Health")) OR (MJSUB.EXACT("Mental Disorders")) OR (TI,IF("personality

disorder*")) OR (MJSUB.EXACT.EXPLODE("Personality Disorders")) OR (TI,IF(psychosis or psychotic or schizophrenia)) OR (MJSUB.EXACT.EXPLODE("Schizophrenia") OR MJSUB.EXACT("Psychosis")) OR (TI,IF(anxiety) OR MJSUB.EXACT("Anxiety Disorders")) OR TI,IF(depress*) OR (MJSUB.EXACT.EXPLODE("Major Depression")) 738603
S2 (TI,AB((decreas* or prevent* or reduc*) NEAR/6 (crisis or crises or admission* or readmission* or hospitalis* or hospitaliz* or emergency or ED))) 11533
S3 (SU.EXACT("Crisis Intervention")) OR TI,AB(intervention*) 523167
S4 (S1 AND S2 AND S3 AND S4) 556 S5 TI(chlid* OR adolescen*) 529241
S6 S4 NOT S5 534
S7 S4 NOT S5 Narrowed by:Entered date: 01/ 01/ 2004 - 01/ 09/ 2025 462