

Could we improve the lives of people with severe mental health problems through better psychosocial interventions?

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The outcomes of psychosis

Pooled meta-analysis of long-term psychosis studies over 50 years

- Remission rate after first episode has improved in N America, not in Europe
- Recovery rate has not improved, but is better in N America than Europe (pooled estimate: 38% have made a good recovery at 7 yrs) **Lally et al. 2017**

The British Journal of Psychiatry

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Remission and recovery from first-episode psychosis in adults: systematic review and meta-analysis of long-term outcome studies

John Lally ^(a1), Olesya Ajnakina ^(a2), Brendon Stubbs ^(a3), Michael Cullinane ^(a4) ... 

<https://doi.org/10.1192/bjp.bp.117.201475> Published online: 02 January 2018

The course of bipolar disorder

Research is not strong (diagnostic problems hamper), but:

- Most have relapsing/remitting course
- Approx **15% chronically unwell** on long-term follow-up (e.g. 15 yrs – Coryell et al., 1999)
- **16% in remission for 5 years** on 40 year follow up (Angst and Preiseg, 1994):
- **Median time being ill: 20% - 44%** (Carlson et al. 2012; Keck et al., 2003). Majority of time depressed.
- **Little evidence of change in prognosis in past few decades**

A widening mortality gap

Mortality gap for people with bipolar disorder and schizophrenia: UK-based cohort study 2000–2014

Joseph F. Hayes ^(a1), Louise Marston ^(a2), Kate Walters ^(a2), Michael B. King ^(a3) ... 

<https://doi.org/10.1192/bjp.bp.117.202606> Published online: 02 January 2018

Results

Individuals with bipolar disorder and schizophrenia had elevated mortality (adjusted hazard ratio (HR) = 1.79, 95% CI 1.67–1.88 and 2.08, 95% CI 1.98–2.19 respectively). Adjusted HRs for bipolar disorder increased by 0.14/year (95% CI 0.10–0.19) from 2006 to 2014. The adjusted HRs for schizophrenia increased gradually from 2004 to 2010 (0.11/year, 95% CI 0.04–0.17) and rapidly after 2010 (0.34/year, 95% CI 0.18–0.49).

Conclusions

The mortality gap between individuals with bipolar disorder and schizophrenia, and the general population is widening.

Employment rates in psychosis in the UK

Marwaha and Johnson 2004

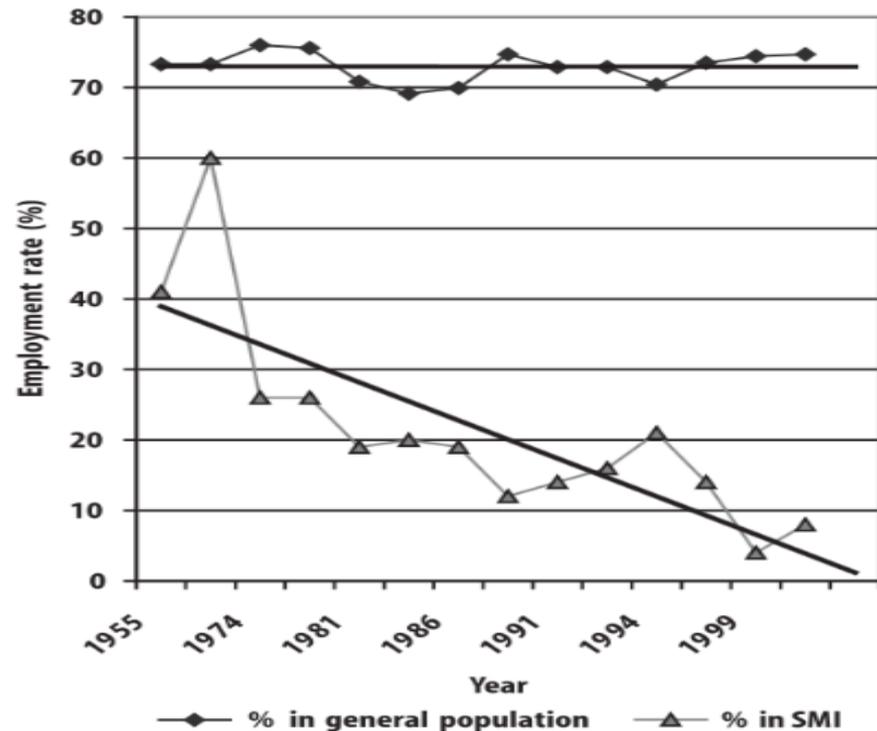
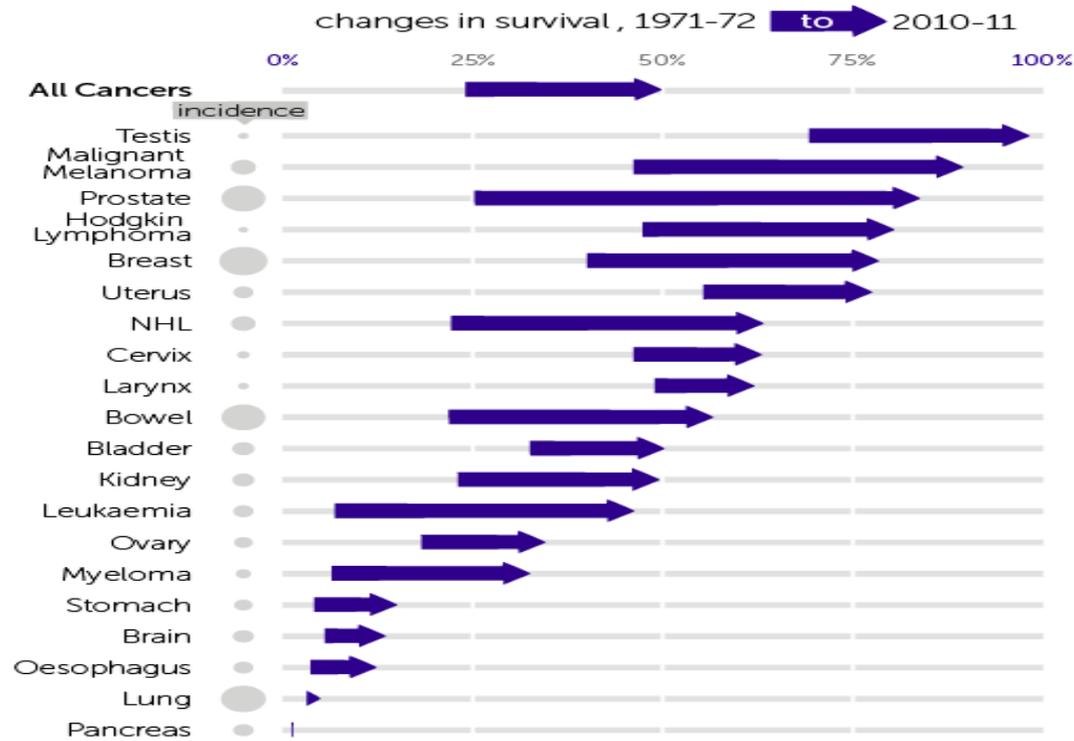


Fig. 1 Employment in the UK general population compared with employment in people with schizophrenia from UK studies

Cancer survival changes 1970-2010



From Cancer Research UK

So....

- We seem to have made little progress in achieving substantial change in outcomes
- At least some other long-term conditions have seen steady progress
- Outcomes may still be better in countries with little mental health care (some dispute about this)

Why have we not done better?

- **Low research investment compared with other LTCs**
- **Neuroscience/Pharmacology**: Still investing in this and waiting for the great leap forward
- **Psychology**: Small benefits so far from interventions that have been hard to implement widely/are usually relatively brief.
- **Innovative service models**: Benefits from EI, but short term. Changing service organisation may not sufficiently change content of care.
- **Social determinants of health**: working against us are the impacts of austerity, inequality etc.

The move out of institutional living – on balance, this has been an achievement over the past 50 years.

Service user priorities for their lives

Findings from two decades of service user involvement in research and service planning:

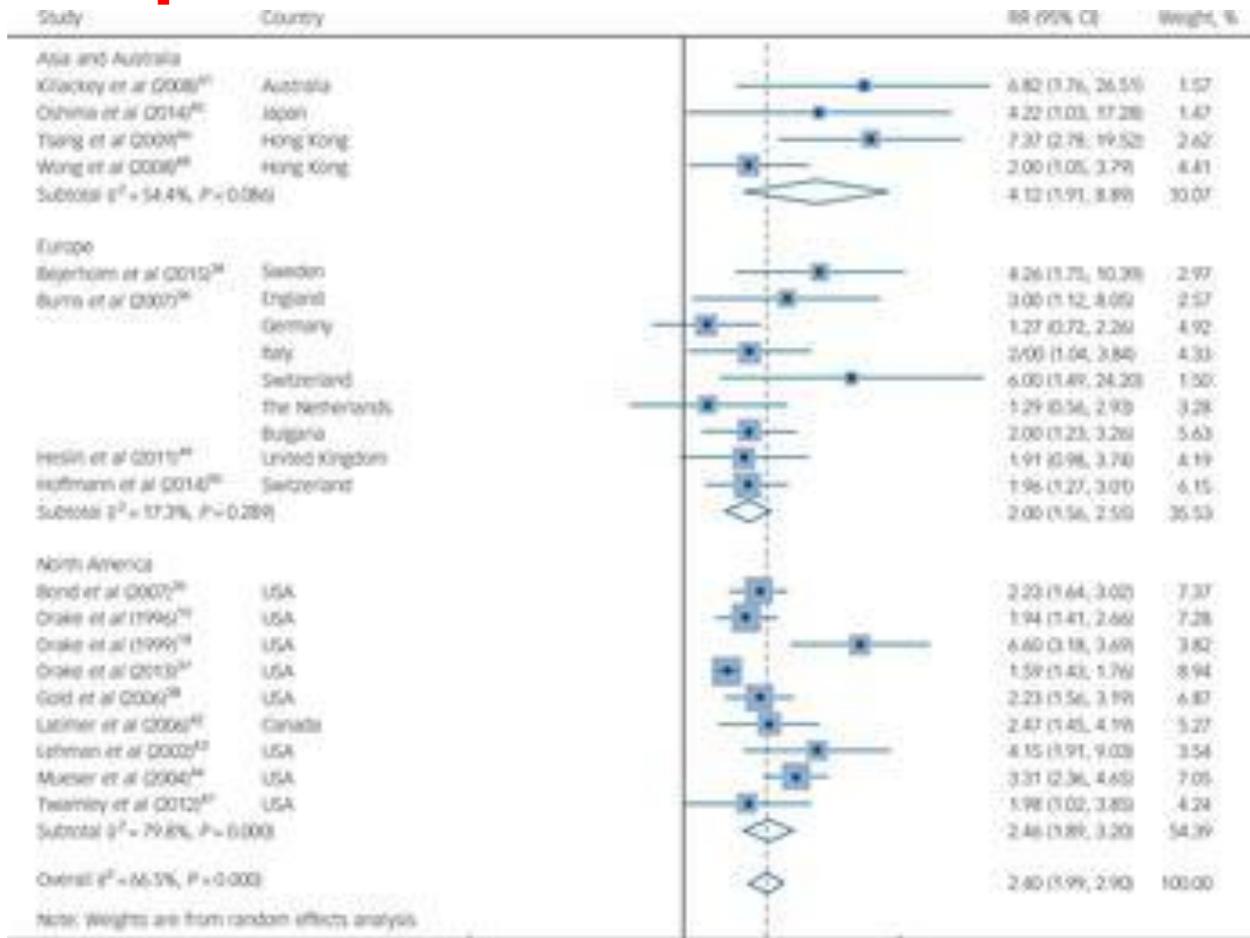
- Clinicians – often focus on risk and symptoms (especially positive)
- Service users more often concerned with autonomy, relationships, well-being, social problems

Many treatment trials – symptoms, relapse, risk events as priorities

How can we do better for people with serious mental health problems?

- Need to engage with people with lived experience – we haven't done well by leaving them out.
- Enriching content and quality of care *throughout* services a priority...
- ...but it has been hard to change practice in routine NHS settings, even when evidence available.
- Potential directions for improving outcomes through enriched delivery of psychosocial interventions:
 - A. Vigorous efforts to implement psychosocial interventions that already have a clear evidence base. E.g. supported employment
 - B. Refining, testing, implementing tools that are already available and promising e.g. self-management
 - C. Developing new intervention strategies e.g. addressing social targets

A. Individual placement and support - **an example of an intervention requiring implementation**



Modini et al 2016

2.4 times increased rate of competitive employment IPS: vs. vocational rehab

Robust across time and country

Little justification for not offering it to all (though without coercion to take unsuitable/unwanted work

The implementation gap

- Widespread failure across healthcare to put in practice interventions found to be effective & cost-effective
- Evidence suggests gap is especially great in mental health
- A well-known example: family intervention to reduce expressed emotion in schizophrenia - delivered to only a small minority despite vast evidence base from 1970s on.
- Digital interventions – a current major implementation challenge
- Estimated 17 year lag from research evidence to practice (healthcare generally).
- Little expectation that when research shows an intervention to be effective it will then become widely available in practice.

The new discipline of Implementation Science

Rapidly rising across health research.

Aiming for knowledge that generalises beyond a specific intervention

Questions like:

- What obstacles prevent take-up of effective interventions?
- What are the organisational and attitudinal factors that influence implementation?
- What strategies are effective in overcoming research-to-practice gap quickly?

Currently many flowers bloom – plethora of frameworks & approaches, slight chaos

But crucial importance recognised – a good area in which to become an expert (or if not – try to make friends with some implementation scientists)



B. Self-management as an intervention ready for refining, testing & implementing

Supporting self-management is inseparable from the high-quality care for Long Term Conditions.

Commissioners and health-care providers should promote a culture of actively supporting self-management as a normal, expected, monitored and rewarded aspect of care. Further research is needed to understand how health service managers and staff can achieve this culture change in their health-care organisations.

Trish Greenhalgh – 2014

(Synthesis of evidence on self-management in long term conditions)

Self-management

- Relevant across all conditions, especially long term ones.
- *the tasks . . . individuals must undertake to live with one or more chronic conditions . . . [including] . . . having the confidence to deal with medical management, role management and emotional management of their conditions* Greenhalgh, 2014
- Effectiveness established for most LTCs where well investigated.
- Tends to be **supported** in LTCs – works best integrated with services **i.e. not a substitute for good quality care**
- In mental health frequent components include:
 - Psychoeducation about mental illness and its treatment (in order to make informed decisions about care)
 - Recognition of early warning signs of relapse and development of a relapse prevention plan
 - Coping skills for dealing with persistent symptoms
 - Working towards individualised recovery goals

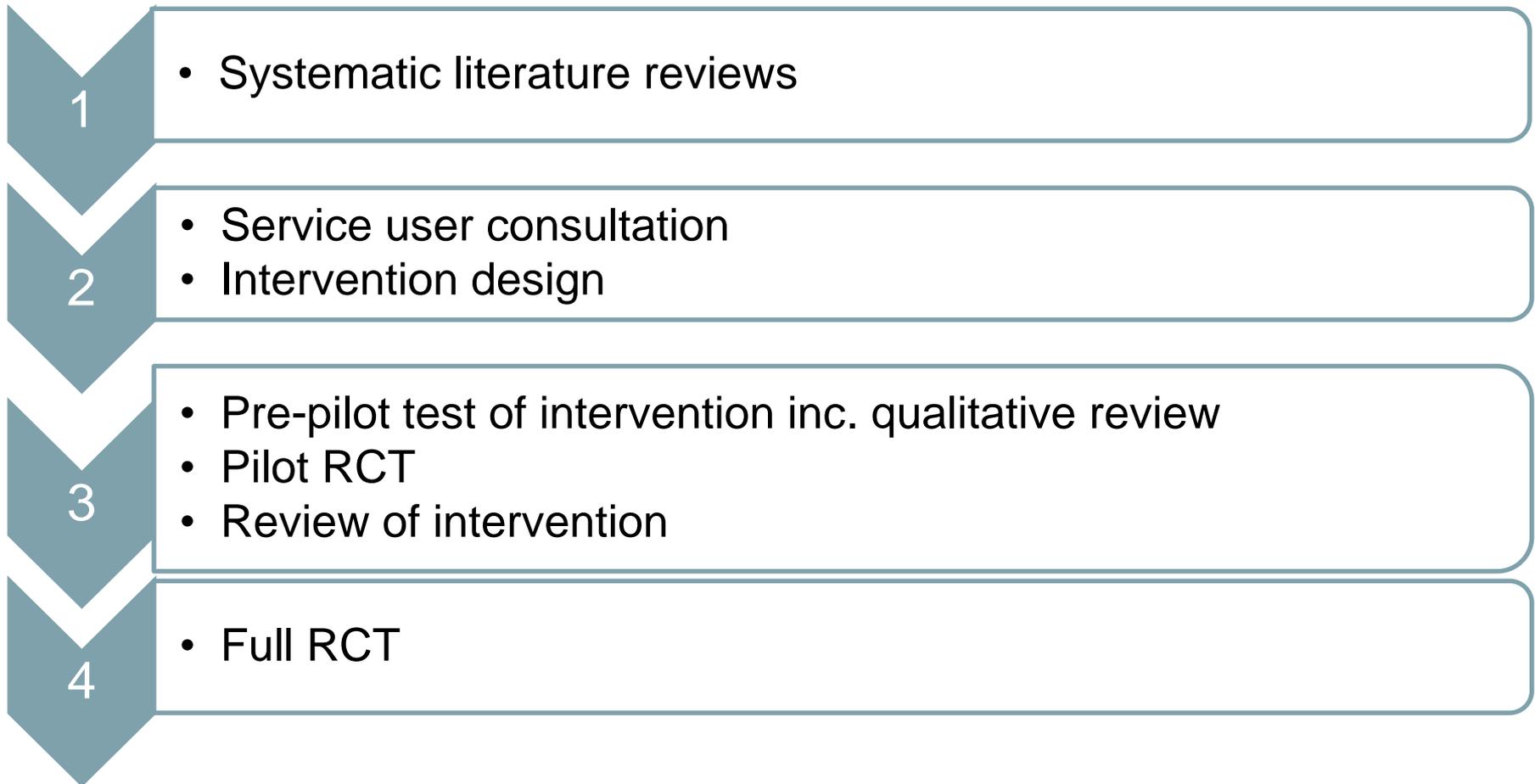
Lean et al.: Meta-analysis of self-management intervention in mental health (in submission)

- Thirty-seven randomised controlled trials meeting criteria were identified, of which 35 provided usable data for meta-analysis.
- From the meta-analysis, self-management interventions conferred benefits in terms of reducing symptoms and length of admission, and improving recovery, hope, functioning and quality of life both at the end of treatment and at follow up.
- Most effect sizes small to medium.

CORE study: rationale for self-management in crisis teams

- High rates of readmission to acute care after CRT episode (approx 50% in 1 year – Hayes et al 2016)
- Some evidence to support self-management (including relapse prevention, crisis planning, setting recovery goals)
- Self management approaches such as relapse prevention not well implemented in practice
- Peer support – highly favoured, but no clearly evidence-based model
- Transition from CRT to continuing care can be abrupt

CORE Intervention development



Stage 1: Two systematic reviews

Peer support for SMI (Lloyd-Evans et al. 2014)

- No compelling evidence for the effectiveness of peer support in psychosis (some in depression)
- Peer support may help with recovery outcomes such as hope, empowerment

Self-management for SMI (revised Lean et al. 2018)

- Some short and long-term benefits from self-management (symptoms, QoL, hope)
- Little evidence re effects on relapse
- Some successful programmes were **peer-facilitated**

➤ ***A peer-delivered self-management programme is a reasonable way to try to support people following a mental health crisis***

Stage 2: Consultation with service users

- **High acceptability:** Positive views towards such a programme
- **Content:** Mutual Support, practical support & mental health related self management support.
- **Modes of delivery:** All acceptable but 1:1 preferred with flexibility of where, when etc.
- **When:** After CRT discharge
- **Peer Qualities:** lived experience very important (empathy, complement professional support)
- **CRT staff:** positive, but highlighted issues of risk management, supervision

Stage 2 – Intervention design and piloting

- Participants randomised to intervention group assigned a peer support worker (PSW) and a self-management workbook (based on resources from Julie Repper and Rachel Perkins)
- Ten hour-long sessions with PSW, within three months of baseline
- PSWs supervised in groups weekly by clinicians within CRTs, individually every few weeks
- Initial feasibility pilot: 11 participants, no controls
- Qualitative interviews with participants, peer support workers, clinicians to refine intervention

“It was more being with a human, not with someone who learned things from the book. Because I am an intelligent person; I read lots of books and all that, but sometimes it's actually better to learn from a person who learnt from life, who went through things in life and experienced them organically, not just memorised them or something”

Stage 3 – Pilot RCT

- 7 PSWs with Islington CRT
- 40 participants took part: 20 intervention, 20 control
- Pilot confirmed main trial feasibility

Stage 4 – Full RCT

- Recruited from 6 trusts – mixture of urban and rural settings
- 440 total (40 from pilot)
- Inclusion criteria:
 - >1 week on CRT caseload
 - Understanding English
 - <1 month from discharge to study entry
 - Capacity to consent
- 50% psychosis/bipolar disorder
- Peer delivered self management support vs. booklet only

Self-management booklet

- Content (worked on with PSW for experimental group):
 - 1. Moving on after a crisis (re-establishing social networks and community functioning; identifying values, responsibilities and activities)
 - 2. Keeping well (developing sense of identity; setting and keeping routines; identifying constructive behaviours and avoiding destructive ones)
 - 3. Managing ups and downs (identifying triggers, early warning signs; action plans)
 - 4. Goals and dreams (planning strategies; sources of information and support)
- Control group participants are sent booklet, but no further guidance or help

Results

Primary outcome: readmission to an acute service within 1 year:

Experimental group: 64/218 (29%)

Control group: 83/216 (38%)

Odds ratio: 0.66[0.43, 0.99]^a

Outcomes	Control group		Intervention group		Coefficient* [95% CI]
	n/N or median	% or (IQR)	n/N or median	% or (IQR)	
Secondary outcomes					
Satisfaction with care	26	(20, 29)	26	(23, 30)	1.96[1.03, 2.89] ^b
Time (days) to first readmission	86	(43, 180)	112	(42, 242)	0.71[0.52, 0.97]
Days in acute care in 1 yr	0	(0, 24)	0	(0, 26)	1.01[0.76, 1.36]
Self-management skills	50	(8)	51	(8)	1.06[-0.49, 2.61] ^b
Self-rated recovery	55	(16)	57	(16)	2.90[0.08, 5.72] ^b
Symptom severity	41	(12)	39	(12)	-1.08[-3.17, 1.01] ^b
Loneliness	22	(20, 24)	22	(19, 24)	0.03[-0.66, 0.73] ^b
Social network size	12	(6)	12	(5)	-0.06[-1.02, 0.90] ^b

Discussion

- Positive result: experimental hypothesis of an effect on the primary outcome confirmed
- Mixed intervention: not clear what critical ingredients are
- Combined test of self-management and peer support
- Considerable use of recovery workbook among controls makes picture less clear
- No really clear effect on symptoms, recovery etc. (though some evidence of difference in satisfaction) – maybe measures too global
- Qual evidence – seemed to work well for both peers and recipients
- Digital version of workbook – not taken up much

Could self-management improve course of severe mental health problems?

- Our study adds to an already significant evidence base for self-management.
- Currently sporadically implemented (WRAP, IMROC)
- Has potential to be implemented throughout day-to-day care and beyond discharge
- Peers – particularly well-placed to deliver, combination of peer & self-management impressive in reducing relapse in our study
- But if it is to be part of routine long-term care, clinicians will need to support too.
- **Challenge now:** find ways of weaving into fabric of NHS mental health care
- Combine with other simple evidence-based interventions with potential to improve care for many – **shared decision making, carer psycho-ed, advance decisions.**

3. Social interventions as a potential tool to improve outcomes & lives

Well established relationship (probably bidirectional) between mental illness and social adversity, but:

- **Guidelines – many drug & psychological interventions recommended, but:**
 - NICE on depression: consider befriending for chronic depression
 - NICE on psychosis: supported employment, possibly peer support
- **Public mental health:** many aspirations to focus on social targets for prevention, few evidence-based programmes.

Why is social the poor relation in the biopsychosocial intervention triad?

- **Social targets are at multiple levels & in many sectors** – at societal, community, family, individual levels, sectors include health, social care, education, workplace etc.
- **Fundamental change may require political action:** are we distracting from need for fundamental social change with initiatives to reduce impact of poverty & inequality?
- **Is involvement of professionals/health researchers in areas like friendship & sexual relationships too paternalistic?**
- **Should we be standardising social interventions?** Many already delivered in various social care/charity sectors
- **Relatively under-developed state of social care research?**

The case for researching social interventions in mental health

- **Outcomes of mental illness not much improved through several decades of neuroscience/psychological research:** a fresh opportunity to improve prognosis through focus on the social
- **Service user priorities for research:** tend to emphasise reducing burden of stigma, social exclusion, social adversity
- **Considerable investment in untested models** – intuitively appealing models don't always work
- **Guidelines tend to require robust evidence** – e.g. shift away from social in new EIP guidelines in absence of evidence
- **Call for more prevention in mental health** – large proportion of potential targets are social

Targets for social interventions in mental health - examples

	National	Community	Small group/family	Individual
General population	Anti-austerity measures	Improvements to built environment	Workplace wellbeing interventions	Mental health campaign promoting self-help
High risk populations e.g. perinatal, older people	Initiatives to alleviate poverty among older people	Centres promoting social life for new mums	Bringing young people into care homes	Apps to allow new mums to find company
People with common mental health problems		Access to leisure centres for people with depression	Education about loneliness for GP practices	Social prescribing in primary care
Secondary care service users			Peer support groups in day services	Supported employment

Social interventions among people with severe mental health problems

Substantial supporting evidence	Preliminary evidence	Minimal evidence
Supported employment (in psychosis)	Interventions to increase social network size	Loneliness interventions
	Peer support to improve mental health outcomes (more for depression)	Support in sexual relationships
	Sexual health interventions	Support with financial problems & debt
		Support in successful parenting

Anti-loneliness interventions: an example of a social target for intervention development



Tweets	Following	Followers	Likes	Lists	Moments
788	243	857	103	2	0

Mental Health and Loneliness Network
 @UCL_Loneliness

Tweeting about research on loneliness/social isolation & mental health and the work of the new @UKRI_news -funded cross disciplinary network on this theme

📍 UCL Division of Psychiatry

Tweets **Tweets & replies** **Media**

📌 Pinned Tweet

 **Mental Health and Loneliness Network** @UCL_Loneliness · Sep 8

1. Here is a thread to explain Loneliness and Social Isolation in Mental Health #MHLoneliness network, one of 8 new #MentalHealthNetworks funded by the @UKRI_News. It will be jointly led by @soniajohnson & @DrAPitman both @UCLPsychiatry . ukri.org/news/uk-resear...

💬 2 ↻ 33 ❤️ 40 |||

Show this thread

**SOCIAL ISOLATION IN
MENTAL HEALTH:**

A CONCEPTUAL AND METHODOLOGICAL REVIEW

SCOPING REVIEW 14

What is loneliness?

- Subjective, unpleasant state
- Not solitude
- Mismatch between what you have and what you want
- Related to (but distinct from) social networks, social isolation, social capital, living alone, marital status and other concepts



JINGYI WANG, BRYNMOR LLOYD-EVANS, DOMENICO GIACCO,
REBECCA FORSYTH, CYNTHIA NEBO, FARHANA MANN, SONIA JOHNSON

How can you measure that?

- Complex, personal experience: fair to reduce to checklist?
- Validated measures: UCLA loneliness scale, DeJong Gerveld
- Widely used, reasonable psychometrics
- But not necessarily a close fit to personal experience

C indicates "I often feel this way"
 S indicates "I sometimes feel this way"
 R indicates "I rarely feel this way"
 N indicates "I never feel this way"

1. I am unhappy doing so many things alone	O	S	R	N
2. I have nobody to talk to	O	S	R	N
3. I cannot tolerate being so alone	O	S	R	N
4. I lack companionship	O	S	R	N
5. I feel as if nobody really understands me	O	S	R	N
6. I find myself waiting for people to call or write	O	S	R	N
7. There is no one I can turn to	O	S	R	N
8. I am no longer close to anyone	O	S	R	N
9. My interests and ideas are not shared by those around me	O	S	R	N
10. I feel left out	O	S	R	N
11. I feel completely alone	O	S	R	N
12. I am unable to reach out and communicate with those around me	O	S	R	N
13. My social relationships are superficial	O	S	R	N
14. I feel starved for company	O	S	R	N
15. No one really knows me well	O	S	R	N
16. I feel isolated from others	O	S	R	N
17. I am unhappy being so withdrawn	O	S	R	N
18. It is difficult for me to make friends	O	S	R	N
19. I feel shut out and excluded by others	O	S	R	N
20. People are around me but not with me	O	S	R	N

Scoring:

Make all O's =3, all S's =2, all R's =1, and all N's =0. Keep scoring continuous.

Surely everyone feels lonely sometimes?

- Transient loneliness adaptive?
- Likened to hunger
- Social 'pain'
- Persistent loneliness probably

The issue



‘Risk factors’

- Older & younger people
- Lower income
- Carers
- Living alone/being unmarried/bereavement
- Physical disability, sensory deficits
- Mental health problems
- New mothers, students
- Refugees, ethnic minority groups
- Both men and women affected
- Substantial overlap with risk for mental health problems



REFUGEE
ACTION



Mounting evidence on loneliness impact:

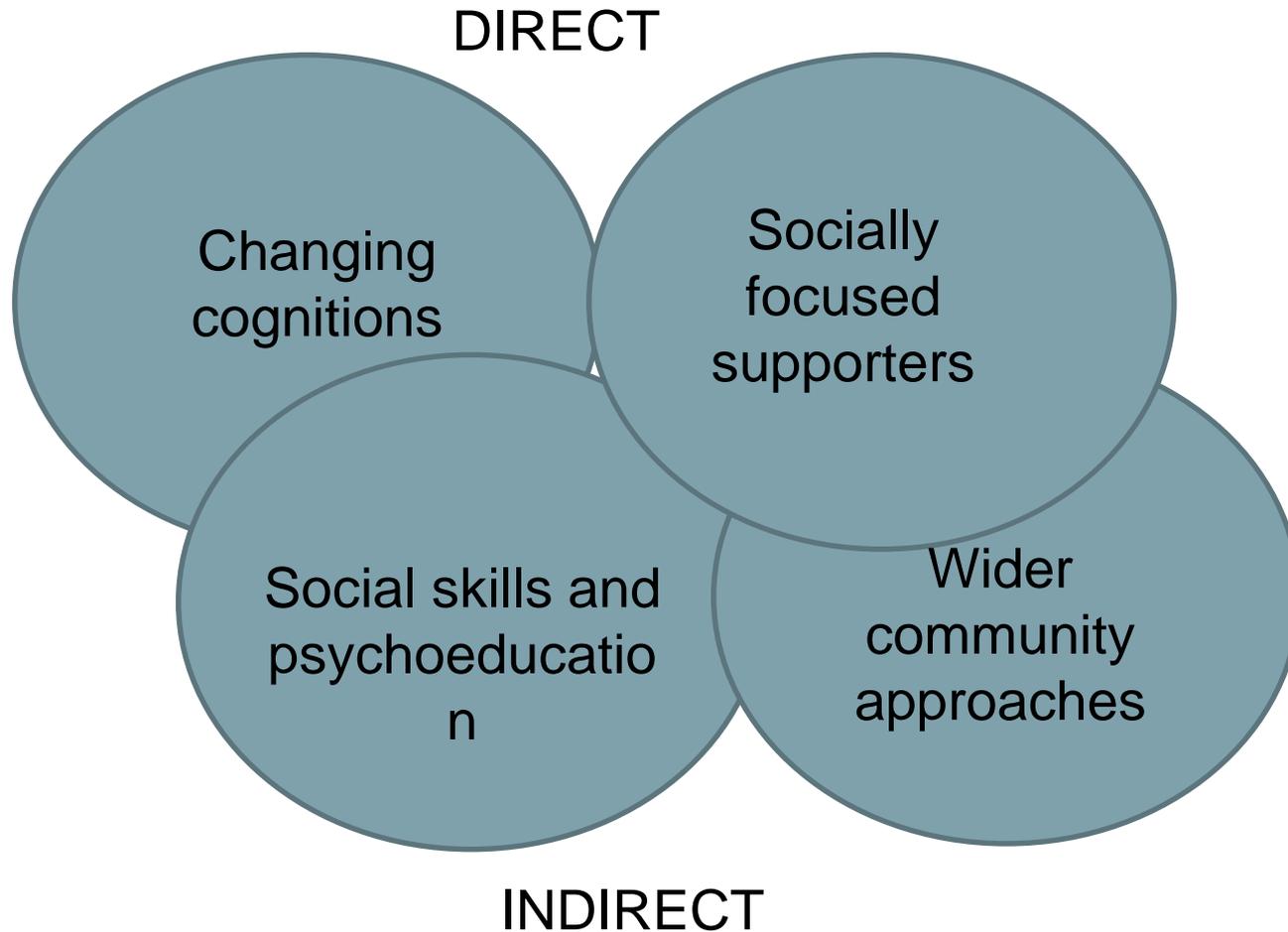
- Numerous physical and psychological impacts
- Poorer outcomes in cardiovascular and respiratory disease
- Sleep problems
- Meta-analysis of 148 international studies: significantly increased risk of premature death
- Evidence for altered immune system function (eg HPA axis, natural killer cell activity, reduced inflammation)

In mental health

- Marked cross-sectional associations between being lonely and:
 - Depression
 - Anxiety
 - Suicide/parasuicide
 - Eating disorders
 - Personality disorder
 - Psychosis

But evidence on longitudinal course/causality more limited

Potential interventions (Mann et al. 2016)



Changing how people think

- CBT - challenging attributional biases, negative evaluations in people's views of other people
- Challenge people's expectations of success overcoming loneliness
- Ten RCTs across different aspects of social relationships/loneliness
- Some evidence of reduction in loneliness over time
- Or **social identity** approach (Haslam et al) – building group membership and social identity

Social skills and psychoeducation

- ‘Teaching’ or improving confidence with social skills etc
- Education about how illness may impact on ability to socialise etc, strategies to manage this
- Education about benefits of tackling loneliness
- Some RCT evidence on effectiveness in increasing social support, not on loneliness

Socially focused supporter

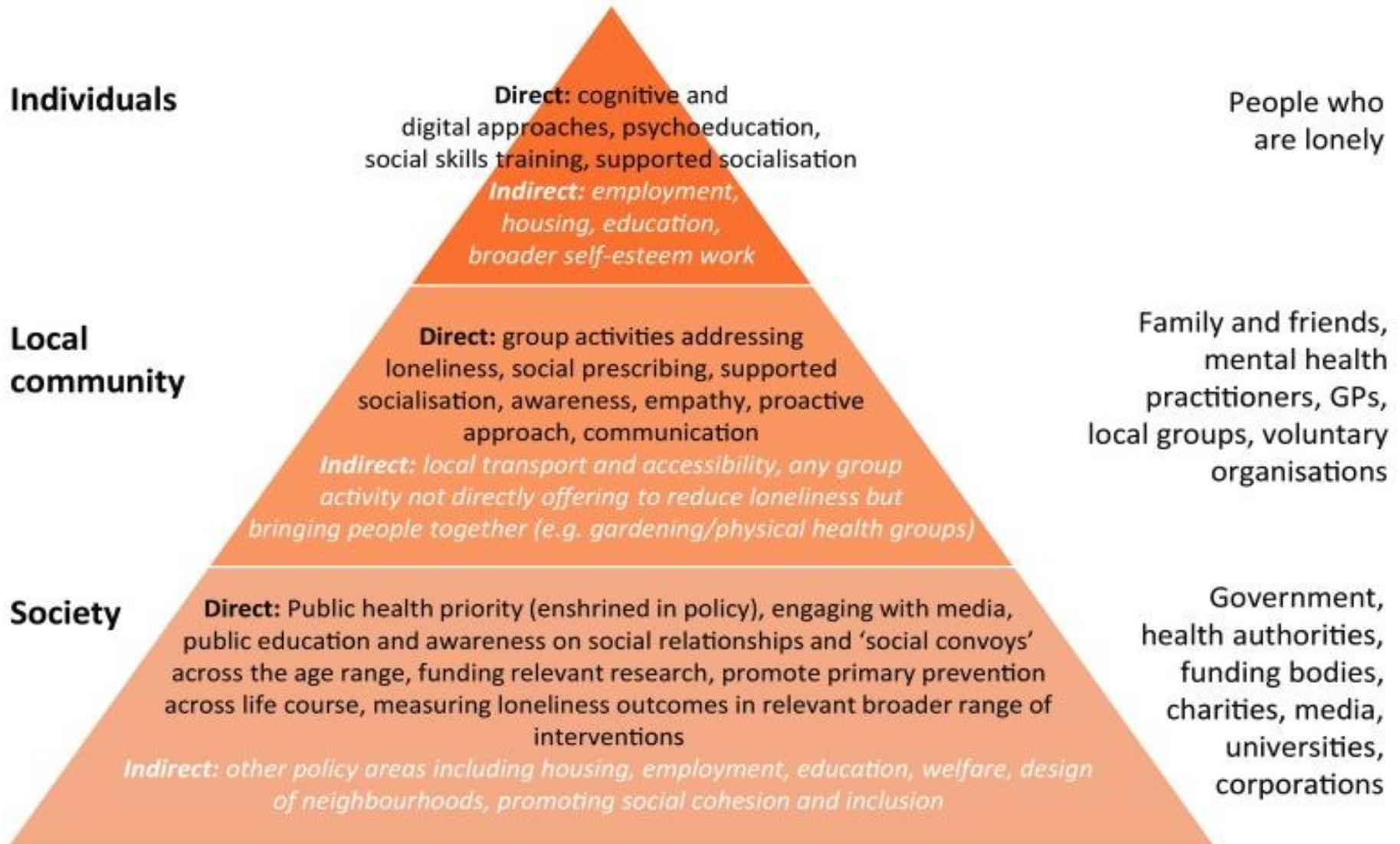
- Support choosing/attending activities
- Often a community navigator or peer supporter
- Evidence from trials very limited despite enthusiasm for it, least effective in most clinically unwell people
- Community Navigator Trial at UCL
- May be combined with **social prescribing** – prescribing activities, sometimes with budget, rather than medication

Wider community approaches

- Asset based community development
 - Mapping community assets
 - Initiatives to develop them and make them more accessible.

City-wide initiatives (MACC in Manchester)
- Lots of scope for digital tech – eg GPs linking people up with what's available.

Farhana Mann, 2016



Loneliness in mental health service users

- Rates are high: in Australian survey of psychosis 80% significantly lonely, depression highly associated with loneliness
- Currently no well-established interventions to reduce loneliness in clinical populations.
- Complex bidirectional relationship between mental health problems and loneliness is an impediment to building theory, developing interventions
- Some adaptation may well be needed of interventions that work in other populations.
- Stigma and self-stigma big issues.
- Better understanding needed of how people experience loneliness, what help they would like
- Aspiration: to improve mental health outcomes by reducing loneliness
- But reducing loneliness may be a justifiable goal in itself

Developing the Community Navigation Intervention

- **Community Navigator Study:** Bryn Lloyd-Evans, Sonia Johnson, Jo Billings, Glyn Lewis, McPIN
- **Co-production approach:** 8 meetings of a study stakeholder working group (experts with lived experience, clinicians, researchers) to support co-production (with McPin Foundation)
- Consultation with experts in the field, including voluntary sector providers of community navigator and social prescribing services
- Reference to relevant literature
- Intervention manual and theory of change model developed



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Welcome

WE are on a mission to help people find things that make them smile. Our website gives you lots of ideas for how you can get involved and we'd love you to join in with our activities. Click here and find out how...



Face to Face



Activities and

The Community Navigator Programme

Structure

- Up to 10 sessions
- Up to 6 months
- £100 budget
- Additional group element
- Adding to standard care
- Training from study team/CDAT practitioners
- Supervision from MH service social workers

Key components

- Mapping my social world
- My connections plan
- Social identity building
- Solution-focused approach
- Help only with social contact/connections

Community navigation case example: C11

C11: Now – Meditation classes, Health Condition Group, Film
 Previously – Sport and outdoors, volunteering, music

	Miss	Maybe	Hit
Volunteering	KCL	City Farm Neighbourhood Centre	
Film	Local film club		Neighbourhood Centre film group
Sport		Local football team Cricket club trips	
Outdoors		City Farm	TH Walking Group (new friend)
Social	Adult Ed	Recovery College Family plans	Neighbourhood Centre (lunch club, film group > weekend trip with new friends)

Reported impacts:

- More active, more confident
- More comfortable with others even if no point of connection (health condition)
- Finding interpersonal contact easier (e.g. brother-in-law)

Feasibility trial combined with qualitative evaluation

- In four London Boroughs, 2015-2018
- 30 experimental vs. 10 controls randomised to Community Navigator vs. directory of local resources

Findings:

- Straightforward recruitment
- High acceptability & good retention
- Hard to take small steps forward in a very anxious population – longer might have been beneficial
- Dissemination day: 3 Dec 2018.
- Full RCT coming soon?

Some challenges for researching social interventions

- RCT evidence more problematic than for less complex interventions:
 - Social context at various levels a major influence on how well a model works (e.g. the job market, the social assets of the community)
 - Community-level interventions are hard to research through RCTs
- Strategies for helping need to be individualised:
 - Changing cognitions vs. helping connect
 - Tailored to interests (music/sport/spirituality....)
 - Reconnecting vs. making new links
 - Peer support vs. back into wider world
 - Digital vs. IRL

Paternalism vs. empowerment vs. activism – how far should the remit of clinicians extend? Clinical or social/political problems?

But – - Mental health service users/survivors often very supportive of this area of work

- Many potential cross-disciplinary collaborations

- Potentially great untapped potential for benefiting quality of life and outcomes

UKRI @UKRI_News · Sep 10

Professor @soniajohnson from @uclnews is the network lead for one of our #MentalHealthNetworks, Loneliness and Isolation.

Read her thoughts about the #research network here and find out more on our website below. 📌

socsj.in/GblQX

“

People with mental health problems are especially at risk of loneliness and social isolation, in part because of stigma. Evidence is emerging that this has considerable negative impact on their quality of life and outcomes of their mental health problems, and we also know that loneliness has adverse effects on physical health.

Currently, we don't have a detailed understanding of the inter-relationships between loneliness and social isolation and mental health, and there are not well-evidenced strategies to reduce loneliness and social isolation among people with mental health problems and thus improve their outcomes. We aim to bring expertise from many perspectives (including lived experience, clinical research, neuroscience, social science, the arts and the built environment), with the aim of seeding major research advances in these areas.

”

Professor Sonia Johnson,
Professor of Social and Community Psychiatry, University College London



UKRI Network on Loneliness and Social Isolation in Mental Health

- Interdisciplinary network to develop collaborations, fund small projects, seed larger ones – from 1 Dec 2018
- One of eight new networks funded by all research councils. Questions:
 - Can we prevent mental health problems through interventions focused on loneliness/isolation?
 - Can we reduce loneliness in people with mental health problems (and so improve outcomes)?
- Disciplines include psychology, social psychiatry, epidemiology, sociology, music, art, architecture, digital technology, sports science....
- Major role for Lived Experience Working Group

In summary

- We should not wait for great leaps forward in pharmacology/psychology to improve lives of people with severe mental health problems
- Enriching the fabric of usual care with better delivery of psychosocial interventions may be the route to improve lives and outcomes of mental health service users.
 - Through rigorous implementation of well-developed models with clear evidence e.g. Vocational support, BFI
 - Through refinement & testing (implementation-evaluation studies) of straightforward evidence-supported interventions e.g. self management
 - By developing & testing novel social interventions
- **Mental health nurses (in alliance with people with lived experience) are very well placed for the task of enriching “routine” NHS care**

This presentation presents independent research undertaken as part of the CORE Study, funded by the National Institute for Health Research (NIHR) under its Programme Grants for Applied Research programme (Reference Number: RP-PG-0109-10078).

The views expressed are those of the author and not necessarily those of the NHS, the NIHR or the Department of Health.

<https://www.ucl.ac.uk/core-study>

This presentation represents independent work funded through the NIHR School for Social Care Research. The views expressed in this presentation are those of the authors, and do not represent those of SSCR, NIHR or the NHS.

<https://www.ucl.ac.uk/psychiatry/research/epidemiology/community-navigator-study>

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