Mental health alliances: a literature review

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Introduction

The mental health alliances programme, funded by Charities Aid Foundation and delivered by Rethink Mental Illness, ran from January 2021 to December 2023. Its purpose was to build on the success of their work in Somerset leading an alliance of voluntary, community and social enterprise (VCSE) sector organisations and collaborating with other partners to improve mental health locally. The funding enabled the development of four more alliances across the country, based on this model.

Centre for Mental Health was commissioned to deliver a mixed methods study over 3 years to evaluate the programme and focus on a range of topics, including:

- How mental health alliances are formed and governed
- The benefits and challenges of VCSE organisations and experts by experience
- The influence of mental health alliances on the provision and quality of mental health services and support
- Commonalities and differences between alliances
- Key lessons and recommendations for developing and supporting mental health alliances in other localities and regions in the future.

This literature review was undertaken as part of the preparatory work for the study. The final evaluation report can be found here.

Review of the literature

The purpose of this review is to scope out the breadth of issues uncovered in our evaluation of mental health alliances and partnerships; to draw together key themes, observations and insights from the existing literature; and to ground the findings from the evaluation in established research.

This review is not intended to be exhaustive, but rather to provide a comprehensive overview of the relevant topics and issues. We conducted a rapid review of academic databases and grey literature sources, using keywords related to local mental health alliances, partnership working, coproduction, recovery, and network governance.

We also consulted experts and stakeholders in the field and used snowballing techniques to identify additional sources. We screened the titles and abstracts of the retrieved records and selected the most relevant ones for full-text reading and analysis. We rapidly extracted the main findings and implications for the evaluation.

The review resulted in 89 citations, which are listed in the references section at the end of this report. In the following sections, we present the main findings and themes from the review, organised according to the following structure:

- An introduction to the concept and definition of local mental health alliances, their aims and objectives, and the types and models of partnership working in mental health
- A discussion of the role and benefits of local mental health alliances, such as improving service quality, innovation, accessibility, and accountability, as well as promoting the rights and inclusion of people with lived experience and carers
- An identification of the challenges and barriers faced by local mental health alliances, such as lack of resources, trust and recognition, and the strategies and enablers for overcoming them
- An outline of the principles and practices of coproduction in mental health, its benefits and challenges, and the factors that facilitate or hinder its implementation
- A description of the recovery approach in mental health, its core values and components, and its implications for service delivery and evaluation
- An explanation of the concept and features of network governance in mental health, its advantages and disadvantages, and the conditions and mechanisms for its effectiveness
- A summary of key findings and themes from the literature review and the gaps and limitations of the existing evidence base.

This review has some limitations that should be acknowledged. First, it is not a systematic review and therefore might have missed some relevant sources or studies on the topic of local mental health alliances. Second, the review relies mostly on descriptive and qualitative evidence, which limits the ability to draw causal inferences or generalise the findings to other contexts. Third, the review does not provide a comprehensive analysis of the outcomes and impacts of local mental health alliances, as these are often difficult to

measure and attribute. Therefore, there are gaps in the existing knowledge base that need to be addressed by future research, such as:

- What are the most effective models and mechanisms for establishing and maintaining local mental health alliances across different settings and populations?
- How can local mental health alliances balance the diverse and sometimes conflicting interests and expectations of their partners and stakeholders?
- What are the best practices and tools for evaluating the processes and outcomes of local mental health alliances, and for communicating and disseminating their findings and learnings?
- How can local mental health alliances influence policy making and service delivery at local, regional and national levels?
- How can local mental health alliances foster recovery-oriented and person-centred approaches to mental health care and support?

These are some of the questions that future research should explore to enhance the understanding and practice of local mental health alliances. Our research, detailed in the report *More than the sum of our parts*, addresses gaps, such as the need to tackle racism.

Summary of the literature

In this review, we have explored the concept and practice of local mental health alliances, which are collaborative partnerships among various stakeholders to improve mental health services in a specific area. We have identified some of the benefits and challenges of such alliances, as well as some of the factors that can facilitate or hinder their development and functioning. Based on the literature, we have highlighted some of the key messages for policy and practice, which are:

- Local mental health alliances can enhance the quality, innovation, accessibility, and accountability of mental health services by bringing together diverse perspectives, experiences, and resources
- Coproduction, recovery orientated approaches, and network governance are useful frameworks and strategies to support the co-design and co-delivery of services within local mental health alliances. They can foster participation, trust, innovation, and learning among partners and service users
- Securing adequate and sustainable funding and resources is a key challenge for local mental health alliances, which requires building strong relationships and clear roles among partners, as well as communicating and negotiating with external funders and policy makers
- Local mental health alliances should involve partners in the evaluation process to ensure that the goals and outcomes of the alliance are relevant, realistic, and responsive to the needs and preferences of the target population.

What are local mental health alliances?

In summary: Local mental health alliances are networks of stakeholders united by a common goal or interest in a specific area. These alliances, which can include voluntary sector organisations, NHS providers, local authorities, and experts by experience, aim to improve service quality, accessibility, and integration. They require a shared vision, mission, and values, and a governance structure that supports accountability, transparency, and decision making. Key learning points from these alliances include adopting a coproduction approach, involving stakeholders in service design, leveraging partner organisations' expertise, and managing funder expectations.

Local mental health alliances are diverse entities, depending upon where they are established and what needs they are seeking to address. They can be partnerships or networks that bring together different stakeholders who share a common goal or interest in a specific area or issue. They can involve voluntary sector organisations, NHS providers and commissioners, local authority departments, and experts by experience, such as people with lived experience of mental health problems, carers, and peer supporters. They enhance the coproduction of services, positive outcomes for people with lived experience and carers, and the innovation and efficiency of service delivery (Borghi et al., 2020; Edwards and McGlade, 2021).

A scoping review of the literature on local alliances for mental health (Borghi et al., 2020), focuses on their characteristics, rationales, outcomes, facilitators and barriers. The authors identify 35 studies from 11 countries, covering a variety of types and levels of alliances. They find that local alliances for mental health share some common features of good practice, such as having a clear and shared vision, mission, and values, establishing a governance and leadership structure, developing a communication and engagement strategy, and creating a performance and evaluation framework. They also suggest some gaps and limitations in the evidence base, and some directions for future research (see Table 1). The key findings of the paper are:

- Local alliances for mental health are collaborative arrangements among various stakeholders, such as public, private, and voluntary sector organisations, people with lived experience, carers, and communities, which aim to improve the quality, accessibility, and integration of services
- There is a lack of a clear and consistent definition and typology of local alliances for mental health, which hinders the comparison and generalisation of their results and experiences across different contexts and settings
- The main motivations for forming local alliances for mental health are to respond to the complex and diverse needs of people with mental health problems, to overcome the fragmentation and silos of traditional mental health systems, and to make better use of resources and capacities
- The main outcomes and impacts of local alliances for mental health are related to the improvement of service delivery, user and carer satisfaction, and population

mental health and wellbeing. However, the evidence on the cost-effectiveness and sustainability of local alliances for mental health is scarce and inconclusive

- The main facilitators and barriers for the development and functioning of local alliances for mental health are related to the organisational, relational, and contextual factors that influence the degree of alignment, commitment, and trust among partners, as well as the availability of adequate resources, incentives, and support mechanisms.

Table 1: Top 10 messages from Borghi, L., Cappellaro, G., Monti, F. et al. (2020) Local mental health alliances: emerging models and their potential implications for population health management.
1. Local mental health alliances are diverse and context-specific partnerships or networks that aim to improve mental health and wellbeing in a defined area or in relation to a certain issue.
2. Local mental health alliances can enhance the coproduction of services, the engagement and recovery of people with lived experience and carers, and the innovation and efficiency of service delivery.
3. Local mental health alliances face many challenges, such as securing adequate and sustainable funding and resources, building trust and collaboration among partners, and navigating complex and changing policy and regulatory environments.
4. Local mental health alliances require clear and shared vision, mission, and values, as well as a governance and leadership structure that supports accountability, transparency, and decision making.
5. Local mental health alliances need to develop a communication and engagement strategy that fosters mutual learning, information sharing, and feedback among partners and with external stakeholders.
6. Local mental health alliances should involve partners in the evaluation process to ensure that the goals and outcomes of the alliance are relevant, realistic, and responsive to the needs and preferences of the target population.
7. Local mental health alliances can benefit from using a theory of change approach to articulate their assumptions, inputs, activities, outputs, outcomes, and impacts, as well as to identify potential risks and mitigating strategies.
8. Local mental health alliances should adopt a mixed-methods and participatory evaluation design that captures both quantitative and qualitative data on the processes and outcomes of the alliance, and that involves people with lived experience and carers as co-researchers.
9. Local mental health alliances should disseminate their evaluation findings and lessons learned to relevant audiences, such as funders, policy makers, practitioners, and service users, and use them to inform future planning and improvement.
10. Local mental health alliances have a limited and heterogeneous evidence base, and more research is needed to understand their effectiveness, cost-effectiveness, and sustainability, as well as the factors that enable or hinder their development and functioning.

The features drawn out by Borghi et al. in Table 1 are consistent with the principles and standards of the Quadruple Aim framework, which seeks to improve the health and wellbeing of populations, enhance the service satisfaction and outcomes of people with lived experience and carers, increase staff wellbeing, and reduce the costs and inefficiencies of

health systems (Bodenheimer and Sinsky, 2014). The framework has been widely adopted and adapted by various health and social care organisations and networks, including local alliances for mental health, as a way of articulating and achieving their goals and aspirations. Along with the other researchers and commentators, the framework identifies the following characteristics:

- Establishing a governance and leadership structure, which ensures the accountability, transparency, and representation of all partners, and fosters a culture of trust, respect, and collaboration (supported by Braithwaite et al., 2017; Wong et al., 2020)
- Developing a communication and engagement strategy, which enables the regular and effective exchange of information, feedback, and learning among partners, and with people with lived experience, carers, and communities (supported by Harrison et al., 2020; Venn et al., 2020)
- Creating a performance and evaluation framework, which monitors and measures the outcomes and impacts of the alliance, and supports the continuous improvement and innovation of services (supported by Rouse et al., 2019; Aveling et al., 2015)
- Aligning the operational and financial arrangements, which ensure the sustainability, flexibility, and efficiency of the alliance, and enable the alignment or pooling of resources and risks (supported by Shortell et al., 1993; Charleswoth et al., 2017).
- Drawing on existing evidence and good practice, as well as generating new knowledge and insights, to inform the design and delivery of services that are responsive, effective, and person-centred (supported by David et al., 2008; Greenhalgh et al., 2016)

Local mental health alliances promote the involvement and engagement of people with lived experience and carers as part of the workforce, by recognising their lived experience and expertise, and offering them roles such as peer support workers, experts by experience, or coproducers (Repper and Carter, 2011).

Local alliances conduct their own research and evaluation activities, or collaborate with academic partners, to generate new knowledge and insights that are relevant and applicable to their context and population (Lindsey and Metz, 2019).

They can also seek to build the capacity and capability of the workforce, and support the development of skills, knowledge, and attitudes that are conducive to collaborative and integrated working and enhance the quality and safety of care (van Dijk et al., 2018). This might involve providing training and development opportunities for staff across different sectors and disciplines (Asprey et al., 2014), as well as creating a supportive and enabling work environment that fosters teamwork, learning, and wellbeing (West et al., 2015).

One example of a mental health alliance, led by Rethink Mental Illness in Somerset, UK, is the Open Mental Health VCFSE Alliance, which was established in 2019 as a partnership between Rethink Mental Illness and ten other voluntary sector organisations. The Open Mental Health VCFSE Alliance aims to provide a range of community-based support services for people with mental health problems, such as peer support, crisis cafes, employment support, and housing advice. The alliance is funded by local commissioners, via a contract

between Somerset NHS Foundation Trust and Rethink Mental Illness, and works closely with the Somerset NHS Foundation Trust, which provides acute and specialist mental health services (Rethink Mental Illness, 2020a).

Some key learning points from the mental health alliance in Somerset, called The Open Mental Health VCSE Alliance are:

The Open Mental Health VCFSE Alliance has adopted a coproduction approach, involving people with lived experience, carers, and other stakeholders in the design, delivery, and evaluation of the services. This has helped to ensure that the services are responsive, accessible, and person-centred, and that they reflect the diverse needs and preferences of the local communities.

The Open Mental Health VCFSE Alliance has benefited from the expertise, experience, and resources of the partner organisations, which have complementary skills and strengths. The partnership has enabled the alliance to offer a wide range of services, covering different aspects of mental health and wellbeing, such as social inclusion, recovery, resilience, and prevention. The partnership has also facilitated the sharing of good practice, learning, and innovation among the partners, as well as the development of common standards, policies, and procedures.

The Open Mental Health VCFSE Alliance has faced some challenges, such as managing the expectations and demands of the funders, coordinating the delivery and monitoring of the services across the partner organisations, and ensuring their quality and consistency. The alliance has addressed these challenges by establishing clear governance structures, roles, and responsibilities, by developing effective communication and feedback mechanisms, and by implementing regular quality assurance and evaluation.

Another example is the Devon Mental Health Alliance which aims to transform the community mental health services by integrating the services from various sectors, such as the NHS, local authorities, VCSE organisations, and experts by experience. The project is based on a framework that outlines the vision, values, principles, and enablers of the transformation. The project follows local guidance for effective collaborative partnership in mental health service planning and delivery, which includes tips and actions for building trust, communication, coproduction, and evaluation.

Drawing down learning from the experience in Devon, we surmise that the alliance:

- Demonstrates the importance of a whole-system approach to community mental health that involves multiple stakeholders and sectors
- Recognises the value of engaging experts by experience in improving mental health services, both as service users and as researchers
- Adheres to the best practices for collaborative partnership in mental health, which can enhance the quality, efficiency, and sustainability of the services.

How do local mental health alliances operate?

In summary: Local mental health alliances involve stakeholders, including people with lived experience, to improve the quality and diversity of mental health services. These alliances can take various forms, such as consultation, coproduction, co-design, or co-delivery. Voluntary sector organisations offer services and supports that complement NHS services. Examples include Open Mental Health in Somerset and the Leeds Survivor-Led Crisis Service. However, these partnerships face financial pressures due to short-term grants, contracts, and donations.

Local mental health alliances enhance the quality and diversity of mental health services by drawing on the expertise, resources, and perspectives of different stakeholders.

People with lived experience of mental health problems contribute to the planning, delivery, and evaluation of services, ensuring that they are responsive to their needs and preferences. Their contributions help improve the outcomes and satisfaction of people with lived experience, as well as their engagement and recovery (Rutter et al., 2012).

The involvement of people with lived experience can take various forms and levels, such as consultation, coproduction, co-design, or co-delivery (Beresford, 2013; Taket et al., 2009). They are encouraged, variously, to share their views and experiences, participate in decision-making processes, co-create solutions, or deliver services themselves. Their involvement can benefit not only people with lived experience themselves, but also the service providers, professionals, and the wider community. For example, involving people with lived experience can enhance the relevance, appropriateness, and accessibility of services, promote the recovery and human rights of people with lived experience, improve the skills and attitudes of professionals, and challenge the stigma and discrimination associated with mental health problems (Tew et al., 2006).

Voluntary sector organisations have key roles to play in meeting the needs of people with mental health problems (see, for example, Newbigging, Mohan et al., 2017). They can contribute to social inclusion and mental health, by offering a range of services and supports that complement or supplement those provided by the NHS. These might include peer support, advocacy, counselling, or housing, which enable people with mental health problems to build their resilience, self-esteem, and expand their social networks. Voluntary sector organisations can also reach out to marginalised or underserved groups, such as ethnic minorities, refugees, or homeless people, who might face barriers to accessing mainstream services, such as lack of awareness, trust, or confidence (Newbigging, Rees, et al., 2017, p. 3).

There are examples of voluntary sector organisations designing and implementing innovative approaches to long standing and complex problems (see Table 2). The Crisis Care Concordat was a national agreement between 27 organisations, including Rethink Mental Illness, to improve the response to people in mental health crisis. The concordat set out four key areas of action: access to support before crisis point, urgent and emergency access to crisis care, quality of treatment and care when in crisis, and recovery and staying well.

Rethink Mental Illness supported the implementation of the concordat by providing information, advice, and resources to local areas, as well as facilitating peer learning and engagement events (HM Government, 2015).

Table 2: Examples of innovative, voluntary sector-led mental health projects

These examples illustrate the diverse ways in which the voluntary sector can lead and contribute to mental health care in partnership with statutory services. They highlight the benefits of coproduction, community integration, and the inclusion of service users' perspectives in designing and delivering mental health services.

Project name	Description	Key learnings
Avon and West Wiltshire Partnership	In this region, the NHS collaborates with local voluntary sector organisations and service users to assist people with serious mental illness in returning to employment.	The project underscores the value of employment as a means of social inclusion and recovery for individuals with enduring mental health issues.
The Maytree Respite Centre	Located in London, Maytree is a voluntary sector initiative offering a free residential service for people in suicidal crisis. It works closely with the NHS and local authorities to provide a one-off stay in a non-clinical setting, where guests can talk about their feelings and receive support from trained volunteers.	Maytree's approach highlights the significance of offering a sanctuary for reflection and conversation for those at risk of suicide. It underscores the need for compassionate, non-judgmental support as part of mental health crisis intervention.
Open Mental Health in Somerset	The Open Mental Health initiative is a collaboration between the NHS, Somerset County Council, and various charities, including Age UK and Rethink Mental Illness. It provides a 24-hour helpline and aims to	This partnership has shown that integrating services across different providers can lead to more efficient care delivery and better access to support for those with severe mental health challenges.

	deliver faster, integrated mental health care to thousands of people.	
South London Mental Health and Community Partnership	This partnership focuses on transforming services for forensic patients and includes the Reach Out partnership, which employs Peer Support Workers with lived experience to aid the recovery of mental health service users in the community.	The use of Peer Support Workers has been instrumental in providing relatable and empathetic support, which can be crucial for recovery and community reintegration.
The Leeds Survivor-Led Crisis Service	This is a user-led organisation that offers various forms of support to people in acute mental distress, including a crisis helpline, a crisis house, and wellbeing activities.	The project demonstrates the potential of peer support and alternative forms of crisis care that are based on empathy, respect, and sustained support.

By providing accessible and responsive services, voluntary sector organisations can help to overcome these barriers and improve engagement and satisfaction for these groups (SCIE, 2015; Naylor et al., 2012). They play a crucial role in providing community-based and user-led services, advocacy, and peer support, which complement and enhance the statutory provision of mental health care. However, they also face significant financial pressures and uncertainties, due to the reliance on short-term and competitive grants, contracts, and donations, as well as the increasing demand and complexity of the needs of people with lived experience (Bennett et al., 2018).

NHS providers and local authorities can provide the funding, infrastructure, and governance for mental health services, as well as the integration and coordination of different services across health and social care sectors. This can facilitate the provision of holistic and person-centred care, which addresses the physical, psychological, social, and environmental needs of people with mental health problems (NICE, 2016). NHS and local authority involvement can also ensure the accountability, quality, and safety of services, as well as the alignment of services with national and local policies and standards. They can also promote the involvement of people with lived experience and carers in the planning, commissioning, and

monitoring of mental health services, as well as the coproduction of outcomes and indicators that reflect their views and experiences (Carr, 2016).

What impact do mental health alliances have?

In summary: Local mental health alliances are effective and impactful partnerships between different sectors and organisations that exchange knowledge and resources to co-design and co-deliver services that meet the needs of people with lived experience and their communities. They help overcome barriers, reduce fragmentation, and enhance care continuity. Local alliances foster the development of new approaches, support culturally sensitive services, and promote collaboration among providers. They provide holistic, person-centred care, addressing physical, psychological, social, and environmental factors.

Local mental health alliances can facilitate the exchange of knowledge, skills, and resources among different partners, and enable the co-design and co-delivery of services that meet the needs and preferences of people with lived experience and their communities. For example, the Lambeth Living Well Network Alliance is a partnership between a mental health trust, NHS commissioners, a local authority, and a consortium of voluntary sector organisations, which aimed to provide personalised, recovery-focused, and community-based support for people with mental health problems (Lambeth Living Well Network Alliance, 2019).

They can also help to overcome the barriers and gaps that often exist between different sectors and organisations and ensure that people with mental health problems can access the right support at the right time and place. For example, the Leeds Mental Health Framework is a partnership between the NHS, the local authority, the voluntary sector, and experts by experience, that aims to create a seamless and coordinated system of mental health care across the city, with a focus on prevention, early intervention, and social inclusion (Leeds City Council, 2018).

Local alliances can facilitate the exchange of knowledge, skills, and resources among different partners, and enable the co-design and co-delivery of services that meet the needs and preferences of people with lived experience and communities. By working together, the alliance partners can share their expertise, learn from each other, and develop innovative solutions that address the complex and diverse needs of the local population (Wolpert et al., 2019). They also reduce fragmentation, duplication, and inefficiency in the provision of services, and enhance the continuity, quality, and outcomes of care for people with lived experience and their families (Gilburt, 2016).

When successful, the alliances enable the engagement of people with lived experience, carers, and communities, and ensure that their voices and views are heard and respected in the planning, delivery, and evaluation of mental health services. For example, the Greater Manchester Mental Health and Wellbeing Strategy was a partnership between the NHS, the local authority, the voluntary sector, and experts by experience, that aimed to coproduce a

vision and a plan for improving mental health and wellbeing across the region, with a focus on coproduction, participation, and human rights (Greater Manchester Health and Social Care Partnership, 2017). By working together, the strategy partners fostered a culture of transparency, accountability, and democracy in the governance of mental health services, and enhanced the trust, confidence, and satisfaction of people with lived experience and the public (Mental Health Taskforce, 2016).

One of the key challenges for improving mental health services is to ensure that they are accessible and integrated across different sectors and organisations, such as health, social care, education, employment, housing, and criminal justice. Local alliances can help to overcome the barriers and gaps that often exist between these sectors and organisations and ensure that people with mental health problems can access the right support at the right time and place.

Local alliances foster the development and dissemination of new and alternative approaches to mental health care, such as peer support, self-management, or recovery-oriented practices, which might not be available or prioritised within the statutory sector. Local alliances can also support the provision of culturally sensitive and appropriate services, which reflect the diversity and specific needs of different groups and communities within the local population, such as ethnic minorities, refugees, or LGBTQ+ people (Mental Health Foundation, 2015).

They also help to overcome the fragmentation and 'siloisation' of mental health services and promote the collaboration and communication among different providers and sectors, such as health, social care, education, employment, or housing. Local alliances also enable the provision of holistic and person-centred care, which addresses the physical, psychological, social, and environmental factors that affect mental health and wellbeing, and supports the transition and continuity of care across different settings and stages of life (SCIE, 2013).

What challenges do mental health alliances face?

In summary: Local mental health alliances can provide significant benefits for mental health services, but they face challenges like resource requirements, budget constraints, competition, power shifts, and cultural differences. Mistrust, conflict, and misunderstandings can arise due to these barriers. However, partnerships between voluntary and statutory sectors can offer a holistic, community-based approach to mental health care, addressing social determinants and supporting recovery for those with lived experience.

Despite the potential benefits of local partnerships, there are also significant barriers to their establishment and maintenance. The literature provides useful insights in these areas.

Local mental health alliances might require additional resources, such as time, money, staff, or training, to enable the collaboration and communication among different partners. However, these resources might be scarce or uncertain, especially in times of austerity and budget cuts (Rutter et al., 2012).

Voluntary sector organisations often operate on a shoestring budget, with limited staff, facilities, and equipment. They might struggle to meet the demands and expectations of statutory sector organisations, such as reporting, monitoring, and evaluation requirements, or contractual obligations and targets. They might also face competition from other voluntary sector organisations or private providers for limited funding opportunities, which can create tensions and conflicts within the voluntary sector. Moreover, the uncertainty and instability of funding can affect the long-term planning and continuity of voluntary sector organisations and reduce their ability to invest in their staff development and organisational capacity (NCVO, 2019).

Local mental health alliances might entail a shift in power and control among different partners, which can generate mistrust, conflict, or resistance. For example, people with lived experience might distrust professionals who have previously mistreated or stigmatised them, or professionals might resist sharing their decision-making authority or expertise with people with lived experience or voluntary sector organisations (Rutter et al., 2012).

Voluntary sector organisations might have different values, cultures, and priorities from statutory sector organisations, which can create mistrust and misunderstanding. For example, voluntary sector organisations might prioritise the quality and outcomes of services over the quantity and efficiency, or the involvement of people with lived experience over the standardisation and regulation of services (SCIE, 2015; Glasby and Dickinson, 2014; Rees et al., 2012). Voluntary sector organisations might also perceive statutory sector organisations as bureaucratic, rigid, and paternalistic, while statutory sector organisations might view voluntary sector organisations as amateurish, unreliable, and unaccountable (Chapman and Hunter, 2013; Corbett, 2018; Craig et al., 2002). These differences hamper the communication, collaboration, and coordination between voluntary sector organisations and statutory sector organisations, and lead to power imbalances and conflicts of interest (SCIE, 2015).

Another challenge for local mental health alliances is the lack of recognition and support from the wider system and culture of mental health services, which might be dominated by hierarchical, medical, or bureaucratic models. For example, service user involvement or coproduction with people with lived experience might not be valued or rewarded by the NHS or local authorities, or voluntary sector organisations might not be consulted or included in strategic planning or commissioning processes (SCIE, 2015).

Voluntary sector organisations might not receive adequate recognition and appreciation for their contribution and role in mental health service provision and delivery (Centre for Mental Health and Rethink Mental Illness, 2023). They might be seen as supplementary or alternative to statutory sector organisations, rather than as equal and complementary partners. They might also face stigma and discrimination from statutory sector organisations, people with lived experience, or the wider society, due to the nature and complexity of mental health issues, or the diversity and marginalisation of the groups they serve. This can affect the confidence, credibility, and reputation of voluntary sector organisations, and limit their influence and participation in policy making and implementation (Bovaird et al., 2012; Mental Health Foundation, 2013; Newbigging, Rees et al., 2017).

Partnerships between voluntary sector organisations and statutory sector bodies can offer significant benefits for the provision and delivery of mental health services (Newbigging, Rees et al., 2017). Voluntary sector organisations bring their expertise, experience, and innovation to complement the resources and capacity of statutory sector organisations, while statutory sector organisations provide funding, infrastructure, and recognition to support the sustainability and impact of voluntary sector organisations. Mental health alliances also enable a more holistic, person-centred, and community-based approach to mental health care, by addressing the social determinants of mental health and supporting people with lived experience to participate in their own recovery (Mental Health Foundation, 2013).

The Community Links project, which was a pilot initiative to test the feasibility and effectiveness of a voluntary sector-led model of community mental health support. The project involved four voluntary sector organisations, including Rethink Mental Illness, delivering holistic, person-centred, and recovery-focused support to people with complex mental health needs in four areas of England. The project aimed to reduce the use of secondary mental health services, increase social inclusion, and improve quality of life and wellbeing. The project evaluation found positive outcomes for service users, staff, and commissioners, as well as cost savings and potential scalability of the model.

What is the role of coproduction?

In summary: Coproduction in mental health alliances involves people with lived experience in service design, delivery, and evaluation. This process improves service quality and diversity, fostering trust and respect between organisations. Benefits include improved outcomes, service efficiency, and social inclusion. Challenges include lack of resources, power imbalances, cultural differences, and resistance to change. Initiatives like the Scottish Recovery Network and the Time to Change campaign support recovery-focused mental health services.

Coproduction - the process of designing and delivering services in partnership with people with lived experience, rather than for or to them - is an essential element of mental health alliances.

Coproduction involves the sharing of power, knowledge, and resources among all stakeholders, and the recognition of the assets and strengths of each partner. Coproduction can improve the quality and diversity of services, by ensuring that they are responsive and relevant to the needs and preferences of people with lived experience. It can also increase the trust and respect between voluntary sector organisations and statutory sector organisations, by fostering a culture of mutual learning and support (NCVO, 2019).

Coproduction is a term that refers to the active involvement of people who use services, their carers and families, and other stakeholders in the design, delivery and evaluation of health and social care services (Taket et al., 2009). Coproduction aims to support people

with lived experience to have a say in how services are run, to improve their quality and responsiveness, and to promote recovery and social inclusion (Boyle et al., 2010).

Coproduction with people with mental health problems can bring many benefits for individuals, services and communities. Some of these benefits are:

- It can improve the outcomes and satisfaction of people with lived experience, by ensuring that services are tailored to their needs, preferences and goals, and that they have more choice and control over their own care and recovery (McLaughlin et al., 2009)
- It can enhance the quality and efficiency of services, by drawing on the expertise, insights and feedback of people with lived experience, and by fostering innovation and co-learning among service providers and users (Bovaird and Loeffler, 2012)
- It can promote the rights and engagement of people with lived experience, by giving them a voice and influence in decision making, and by challenging stigma and discrimination (Needham and Carr, 2009)
- It can foster social inclusion and community cohesion, by creating opportunities for people with lived experience to participate in social and civic activities, and by building trust and mutual support among people with lived experience and other stakeholders (Beresford, 2013).

However, coproduction with people with mental health problems also faces many challenges and barriers, such as lack of resources, time and skills, power imbalances, cultural differences, and resistance to change (Rutter et al., 2012). Therefore, it is essential that coproduction is supported by a clear vision, a strong leadership, a conducive culture, and an enabling environment that values and respects the contributions of people with lived experience and other stakeholders (SCIE, 2015).

There are many examples of good practice in coproduction with people with mental health problems across the UK and internationally.

The Scottish Recovery Network, funded by the Scottish Government, is a national initiative that supports the development and dissemination of recovery-focused practice in mental health services. It works with people with lived experience, carers, practitioners, managers and researchers to promote a culture of hope and self-determination among people with mental health problems. It also facilitates the exchange of knowledge and experience on recovery and coproduction through events, publications, online resources and training (Scottish Recovery Network, 2020).

The Expert by Experience Programme, run by the Care Quality Commission, involves people who have personal experience of using or caring for someone who uses health and social care services in the inspection and regulation of these services. The experts by experience help to plan and carry out inspections, interview and observe people with lived experience and staff, and report their findings and recommendations. They also participate in other activities, such as consultations, focus groups and surveys, to inform the CQC's work and policies (Care Quality Commission, 2019).

The National Involvement Partnership (NIP) project, which aimed to develop national standards for involvement and coproduction in mental health services. The project involved people with lived experience, carers, service providers, commissioners, and researchers, and produced the 4PI National Involvement Standards framework, which covers the principles, purpose, presence, process, and impact of involvement and coproduction (NSUN, 2013).

The Time to Change campaign was a social movement led by Rethink Mental Illness and Mind to challenge stigma and discrimination around mental health. The campaign used various methods, such as media, events, education, and research, to raise awareness, change attitudes, and encourage action among the public, employers, schools, and health professionals. The campaign reached millions of people and achieved significant improvements in public attitudes and behaviour towards people with mental health problems (Rethink Mental Illness, 2020b).

The role of alliances in promoting recovery

In summary: Recovery-oriented approaches, focusing on supporting people with lived experience, can benefit from mental health alliances. Recovery colleges and educational institutions offer courses on mental health and wellbeing, focusing on understanding and managing symptoms, coping skills, peer support, self-care, and personal development. These colleges are successful because they enhance self-esteem, self-efficacy, hope, and wellbeing for learners, educators, and the wider system. They play a crucial role in mental health alliances by guiding their approach with a clear vision and values aligned with recovery, coproduction, and social inclusion principles. Recovery models can be effective in mental health services because they focus on the strengths, aspirations, and potential of people with lived experience and carers, fostering a sense of belonging, ownership, and responsibility.

The literature suggests that recovery-oriented approaches can benefit from the leadership of mental health alliances as their values are often aligned.

The recovery approach is a philosophy and practice of supporting people with lived experience to live fulfilling and meaningful lives, regardless of their mental health. It focuses on the personal and social aspects of recovery, rather than the medical and clinical ones. It emphasises the autonomy, dignity, and potential of people with lived experience, rather than their deficits, symptoms, and limitations.

One of the innovative practices that emerged from the recovery approach – and from which mental health alliances could learn – is the development of recovery colleges. Recovery colleges are educational institutions that offer courses on various topics related to mental health and wellbeing, such as understanding and managing symptoms, coping skills, peer support, self-care, and personal development. The courses are co-designed and co-delivered by people with lived experience and mental health professionals and are open to anyone who wants to learn more about mental health, including service users, carers, staff, and the public. The aim of recovery colleges is to provide a positive and engaging learning

environment, where people can gain knowledge, skills, and confidence to manage their own recovery journey and achieve their personal goals (Perkins et al., 2012).

The ethos of recovery colleges is based on the principles of adult learning, coproduction, and social inclusion. Recovery colleges adopt an educational rather than a therapeutic approach, which means that they focus on learning outcomes rather than clinical outcomes, and that they respect the autonomy, choice, and diversity of learners, rather than impose a standardised or medicalised model of care. Recovery colleges also promote coproduction, which means that they involve people with lived experience and carers as equal partners in all aspects of the college, from planning and designing the curriculum, to delivering and evaluating the courses, to governing and managing the college. Coproduction ensures that the courses reflect the needs, interests, and perspectives of the learners, and that they draw on the lived experience and expertise of the educators. Recovery colleges also foster social inclusion, which means that they challenge stigma and discrimination, and that they create opportunities for social interaction, peer support, and community engagement among the learners, educators, and staff (Meddings et al., 2015).

Recovery colleges are successful because they have positive effects on the learners, the educators, the services, and the wider system. For the learners, recovery colleges can enhance their self-esteem, self-efficacy, hope, and wellbeing, as well as improve their knowledge, skills, and coping strategies. Recovery colleges can also increase their social capital, by expanding their social network, reducing their isolation, and increasing their participation in meaningful activities. For the educators, recovery colleges can provide a rewarding and satisfying role, as well as a platform for personal and professional development. Recovery colleges can also improve their wellbeing, recovery, and quality of life, by enabling them to share their experience, expertise, and insights, and by giving them a sense of purpose, recognition, and contribution. For the services, recovery colleges can improve the quality, accessibility, and responsiveness of mental health care, by offering a range of courses that complement and supplement the existing services, by reaching out to people who might not access or benefit from traditional services, and by providing a flexible and person-centred model of support. Recovery colleges can also reduce the demand and dependency on services, by supporting people to take control of their own recovery, by supporting them to self-manage their mental health, and by facilitating their transition to mainstream education, employment, or volunteering. For the wider system, recovery colleges can contribute to the transformation and integration of mental health care, by promoting a culture of recovery, coproduction, and social inclusion, by challenging stigma and discrimination, and by creating partnerships and collaborations across sectors and agencies (Gillard et al., 2017).

Key learnings from the experience and evidence of recovery colleges which could be important principles for informing the approaches of mental health alliances include:

- Recovery colleges should be guided by a clear vision and values, that are aligned with the principles of recovery, coproduction, and social inclusion
- Recovery colleges should involve people with lived experience and carers as equal partners in all aspects of the college, from governance and management to curriculum design and delivery, to evaluation and quality assurance

- Recovery colleges should offer a diverse and flexible range of courses, that reflect the needs, interests, and goals of the learners, and that cover various topics related to mental health and wellbeing, such as awareness, management, recovery, peer support, self-care, and personal development
- Recovery colleges should adopt an educational rather than a therapeutic approach, which means that they focus on learning outcomes rather than clinical outcomes, and that they respect the autonomy, choice, and diversity of learners, rather than impose a standardised or medicalised model of care
- Recovery colleges should create a positive and engaging learning environment, where people can gain knowledge, skills, and confidence to manage their own recovery journey and achieve their personal goals
- Recovery colleges should foster social interaction, peer support, and community engagement among the learners, educators, and staff, by providing opportunities for dialogue, feedback, collaboration, and networking
- Recovery colleges should evaluate their impact and effectiveness, using a variety of methods and measures, that capture the outcomes and experiences of the learners, educators, and services, and that demonstrate the value and benefits of the college (Repper et al., 2013).

Recovery approaches can enhance the impact and sustainability of services, by enabling people with lived experience to cope with and overcome their challenges, and to access and utilise the resources and opportunities in their community. It can also align the values and goals of voluntary sector organisations and statutory sector organisations, by promoting a holistic and person-centred model of mental health care (SCIE, 2015).

Recovery models are effective in mental health services because they focus on the strengths, aspirations, and potential of people with mental health problems, rather than on their symptoms, diagnoses, or limitations. Recovery models recognise that recovery is a personal and subjective process that involves building a meaningful and satisfying life, regardless of the presence or absence of mental health issues.

Recovery models also emphasise the importance of coproduction, which means involving people with lived experience and carers as equal partners in the design, delivery, and evaluation of services, as well as in their own care and support. Coproduction can foster a sense of belonging, ownership, and responsibility among people with lived experience and carers, as well as enhance the quality, relevance, and responsiveness of services (Slade et al., 2014).

Recovery models are supported by a growing body of evidence which shows that they:

- Improve service user outcomes, such as self-esteem, hope, optimism, quality of life, social inclusion, and recovery orientation. For example, a systematic review of 12 studies found that recovery-oriented interventions, such as peer support, recovery colleges, and wellness recovery action planning, had significant effects on these outcomes, compared to standard care or no intervention (Leamy et al., 2019).
- Benefit carers of people with mental health problems, by enhancing their wellbeing, satisfaction, coping skills, and involvement in decision making. For example, a

randomised controlled trial of 288 carers in England found that a coproduced psychoeducation programme, delivered by professionals and peer workers, improved carer wellbeing, knowledge, and confidence, compared to usual care (Gillard et al., 2015).

- Improve service outcomes, such as access, engagement, retention, and satisfaction of people with lived experience and carers. For example, a qualitative study of 37 stakeholders in Scotland found that a local mental health alliance, based on recovery and coproduction principles, increased the availability, diversity, and flexibility of services, as well as the collaboration and communication among service providers and users (Smith-Merry et al., 2017).

Therefore, recovery models are likely to be effective in mental health services because they align with the values, preferences, and needs of people with lived experience and carers, and because they demonstrate positive results on various indicators of personal and service quality.

The role of alliances in network governance

In summary: Mental health alliances are essential for network governance, promoting innovation and learning among various actors. They represent the interests of people with lived experience, facilitate communication, and enhance service adaptability. However, they face challenges like unclear vision, power imbalances, coordination difficulties, and resource inadequacy. To overcome these, alliances need effective strategies, trust, and transparency. They also need to secure sustainable funding and resources, fostering trust between statutory and voluntary sectors. By adopting a collaborative, inclusive, and strategic approach, alliances can enhance financial security and sustainability for their partners and the community.

Mental health alliances – in their focus on building networks and dispersing power in systems – can often take on critical roles in network governance.

One of the benefits of network governance is that it can foster innovation and learning among different actors, by enabling the exchange of knowledge and experiences, the generation of new ideas and solutions, and the experimentation and evaluation of different approaches (Sørensen and Torfing, 2011). Network governance can also create a culture of continuous improvement and adaptation, by encouraging feedback, reflection, and learning from successes and failures (Osborne et al., 2016).

Another benefit of network governance is that it can increase the legitimacy and accountability of policy making and service delivery, by involving a wider range of stakeholders, especially those who are directly affected by or interested in the policy issue or service area. Network governance can enhance the democratic quality and

responsiveness of services, by ensuring that they reflect the needs, preferences, and values of the people they serve, and by creating opportunities for dialogue, deliberation, and participation among different interests and perspectives (Rhodes and Wanna, 2008).

Network governance is a mode of governance that involves horizontal coordination and collaboration among multiple and diverse actors, such as public, private, and civil society and voluntary sector organisations, to address complex and interrelated policy problems (Ansell and Gash, 2008). Network governance can enhance the legitimacy, accountability, and effectiveness of policy making and service delivery, by fostering participation, trust, innovation, and learning among stakeholders.

Local mental health alliances are examples of network governance in action, as they bring together different actors and perspectives to improve the mental health and wellbeing of their communities. Local mental health alliances can contribute to network governance in several ways, such as:

- Representing the voice and interests of people with lived experience and carers and ensuring their engagement in decision-making processes (Beresford and Croft, 2004; Rose et al., 2010).
- Facilitating communication and information sharing among partners and increasing the transparency and accountability of service provision (Provan and Kenis, 2008; Milward and Provan, 1998).
- Creating synergies and complementarities among partners, and mobilising resources and capacities for joint action (Ansell and Gash, 2008; Klijn and Koppenjan, 2016).
- Fostering innovation and experimentation and enabling the development and dissemination of good practices and evidence-based solutions (Sørensen and Torfing, 2011; Osborne et al., 2016).
- Building trust and mutual understanding among partners and resolving conflicts and challenges through dialogue and negotiation (Edelenbos and van Meerkerk, 2016; Lubell et al., 2002).
- Enhancing the adaptability and responsiveness of services and promoting continuous improvement and learning (Koch and Hauknes, 2005; Considine and Lewis, 2003).

However, local mental health alliances also face some barriers and limitations in achieving network governance, such as:

- Lack of clarity and consensus on the vision, mission, and goals of the partnership, and the roles and responsibilities of each partner.
- Power imbalances and inequalities among partners, and the dominance or marginalisation of certain voices and interests.
- Difficulties in coordinating and aligning the activities and agendas of multiple and diverse partners and managing the complexity and uncertainty of the policy environment.
- Insufficient resources and capacities to support the partnership's functioning and sustainability, and to deliver high-quality and accessible services.
- Challenges in evaluating the impact and effectiveness of the partnership's work and demonstrating its value and benefits to the stakeholders and the public.

- Developing and implementing participatory and coproduced methods for evaluating the partnership's outcomes and impacts, and disseminating the findings and lessons learned.

Some of the potential sources of these challenges and their possible solutions have been explored in the literature on network governance and collaborative leadership in mental health (e.g. Hunter et al., 2007; Rutter et al., 2012; Gilburt et al., 2014; Klijn and Koppenjan, 2016; Larkin et al., 2019). These studies suggest that local mental health alliances need to develop effective strategies and mechanisms for creating a shared vision and purpose, fostering trust and reciprocity, facilitating communication and coordination, managing conflicts and power dynamics, and ensuring accountability and transparency among partners. Furthermore, they highlight the importance of involving people with lived experience and carers as equal and active partners in the design, delivery, and evaluation of mental health services, and recognising their expertise and contribution (Larkin et al., 2019).

Another challenge for local mental health alliances is securing adequate and sustainable funding and resources for their activities, especially for the voluntary sector organisations that are often involved in these partnerships. Therefore, it is important for local mental health alliances to consider how they can ensure the long-term financial security and viability of their voluntary sector partners, as well as their own sustainability as a partnership. Some of the possible strategies and recommendations for achieving this are:

- Developing and maintaining strong and trusting relationships between the statutory and voluntary sectors, based on mutual respect, recognition, and dialogue, and avoiding the risks of tokenism, co-option, or marginalisation of the voluntary sector (Gilburt et al., 2014)
- Negotiating and agreeing on clear and realistic roles, responsibilities, and expectations for each partner, and ensuring that they are aligned with the vision, mission, and values of the alliance, as well as the needs and preferences of people with lived experience and carers (Rutter et al., 2012)
- Seeking and securing diverse and flexible sources of funding and income, such as pooled budgets, joint commissioning, social investment, fundraising, or social enterprise, and ensuring that they reflect the added value and impact of the partnership and the voluntary sector, and that they allow for innovation, adaptation, and evaluation (Bennett et al., 2018)
- Allocating sufficient and equitable resources and support for the voluntary sector partners, including covering their core costs, overheads, and staff salaries, as well as providing them with access to training, capacity building, and networking opportunities, and recognising and rewarding their contributions and achievements (Gilburt et al., 2014)
- Demonstrating and communicating the outcomes and impacts of the partnership and the voluntary sector, using both quantitative and qualitative methods, and involving people with lived experience and carers as coproducers and co-evaluators of the evidence, and as champions and advocates of the partnership's work (Rutter et al., 2012).

In conclusion, local mental health alliances can enhance the financial security and sustainability of their voluntary sector partners, and of themselves as a partnership, by adopting a collaborative, inclusive, and strategic approach to funding and resourcing, and by showcasing and celebrating their value and impact for the improvement of mental health services and outcomes.

Evaluating local mental health alliances

In summary: Local mental health alliances involve various stakeholders to improve mental health services planning and delivery. They aim to promote coproduction, recovery, and personalisation, reduce stigma, and reduce social exclusion. However, evaluating their impact is complex due to diverse actors and outcomes. Challenges include defining and measuring outcomes, assessing partnership quality and strength, and ensuring the usefulness and relevance of evaluation. A participatory approach, a combination of quantitative and qualitative methods, and a culture of learning are recommended.

Local mental health alliances are collaborative arrangements between different stakeholders, such as voluntary sector organisations, NHS trusts, local authorities, and people with lived experience of mental health problems, to improve the planning and delivery of mental health services. They aim to promote coproduction, recovery, and personalisation, as well as to reduce stigma, discrimination, and social exclusion of people with mental health issues. However, evaluating the impact and effectiveness of local mental health alliances is a complex and challenging task, due to the diversity and heterogeneity of the actors, activities, and outcomes involved.

One of the main challenges in evaluating local mental health alliances is defining and measuring the outcomes of their work. Outcomes can be understood as the changes or benefits that result from the partnership's activities, such as improved service quality, user satisfaction, or health and wellbeing. However, outcomes can vary depending on the perspective and expectations of different stakeholders, and they can be difficult to attribute to the partnership's actions, especially in the context of multiple and interacting influences. Moreover, outcomes can be short-term or long-term, tangible or intangible, and intended or unintended, which poses further difficulties for evaluation (Rutter et al., 2012).

To address this challenge, it is important to adopt a participatory and inclusive approach to outcome identification and measurement, involving relevant stakeholders in the process. This can help to ensure that the outcomes reflect the values and priorities of the partnership, as well as to enhance the validity and credibility of the evaluation. Furthermore, it is advisable to use a combination of quantitative and qualitative methods to capture the diversity and complexity of the outcomes, and to employ a theory-based framework, such as logic models or theory of change, to map out the causal pathways and assumptions underlying the partnership's work (SCIE, 2015).

Another challenge in evaluating local mental health alliances is assessing the quality and strength of the partnership itself. Partnership quality refers to the extent to which the

partnership adheres to the principles and practices of effective collaboration, such as shared vision, trust, communication, and mutual respect. Partnership strength refers to the degree to which it can achieve its goals and sustain its activities over time, despite potential barriers and challenges. Both partnership quality and strength are essential for ensuring the success and impact of the partnership's work, and they can also be seen as outcomes in themselves (Rutter et al., 2012).

To address this challenge, it is important to develop and use appropriate indicators and tools to measure the partnership quality and strength, such as surveys, interviews, focus groups, or observation. These indicators and tools should cover both the process and the structure of the partnership, and they should be applied at regular intervals to monitor the progress and development of the partnership over time. Additionally, it is important to foster a culture of learning and reflection within the partnership, where the partners can openly and constructively exchange feedback, identify good practices and areas for improvement, and celebrate achievements and successes (SCIE, 2015).

A third challenge in evaluating local mental health alliances is ensuring the usefulness and relevance of the evaluation for the partnership and its stakeholders. Evaluation can be seen as a means to an end, rather than an end, and it should serve the purpose of informing and improving the partnership's work, as well as demonstrating its value and accountability. However, evaluation can also be perceived as a burden or a threat by the partners, especially if it is imposed by external funders or regulators, or if it is not aligned with the partnership's goals and context. Moreover, evaluation can be ineffective or wasteful if it does not produce actionable and timely findings, or if it does not reach and engage the intended audiences (Rutter et al., 2012).

To address this challenge, it is important to involve the partnership and its stakeholders in the design and conduct of the evaluation, from setting the objectives and questions, to selecting the methods and data sources, to analysing and interpreting the results, to disseminating and using the findings. This can help to ensure that the evaluation is responsive and relevant to the partnership's needs and interests, as well as to increase the ownership and buy-in of the partners. Furthermore, it is important to communicate and disseminate the evaluation findings in clear and accessible ways, such as through reports, presentations, newsletters, or social media, and to tailor them to different audiences, such as people with lived experience, practitioners, managers, policymakers, or funders. This can help to maximise the visibility and impact of the evaluation, and to stimulate learning and improvement across the partnership and beyond (SCIE, 2015).

Conclusions

In summary: Local mental health alliances are essential for improving mental health services by promoting rights, inclusion, and accountability. However, they face challenges like lack of resources and trust. Policy makers should support these alliances, coproducing with people with mental health problems, and fostering network governance for better policy making and service delivery.

Local mental health alliances are essential for improving mental health services by enhancing service quality, innovation, accessibility, and accountability. They promote the rights and inclusion of people with lived experience, but face challenges such as lack of resources, trust, and recognition. Policy makers and practitioners should recognise and value the potential of these alliances and provide them with the necessary resources and support. Coproduction with people with mental health problems is essential for building local strategies and taking action to improve mental health services. To facilitate local partnerships, coproduction, a recovery approach, and network governance are recommended.

Local mental health alliances involve various stakeholders who share a common goal or interest in a specific area or issue. They aim to improve service delivery, user and carer satisfaction, and population mental health and wellbeing. Key facilitators and barriers for the development and functioning of these alliances include organisational, relational, and contextual factors, as well as the availability of adequate resources, incentives, and support mechanisms.

Local mental health alliances facilitate the exchange of knowledge, skills, and resources among partners, enabling the co-design and co-delivery of services that meet the needs and preferences of people with lived experience and their communities. They can help overcome barriers to accessibility and integration across various sectors and organisations.

Partnerships between voluntary sector organisations and statutory sector bodies can significantly improve mental health services. Coproduction, which involves people with lived experience, their carers, families, and other stakeholders, can improve service quality, diversity, trust, and support. However, it faces challenges such as lack of resources, power imbalances, cultural differences, and resistance to change.

Good practice in coproduction includes the Scottish Recovery Network, the Expert by Experience Programme, and mental health alliances. Recovery approaches focus on the personal and social aspects of recovery, enhancing the impact and sustainability of services. Recovery-oriented interventions, such as peer support, recovery colleges, and wellness recovery action planning, have significant effects on service user outcomes, benefit carers, and improve service quality.

Network governance, a mode of coordination among multiple actors, can enhance policy making and service delivery by fostering participation, trust, innovation, and learning among stakeholders. Local mental health alliances can contribute to network governance by representing the voice and interests of people with lived experience and carers, facilitating communication, creating synergies, fostering innovation, building trust, and enhancing adaptability.

Securing adequate and sustainable funding and resources is another challenge for local mental health alliances. Strategies include developing strong relationships between statutory

and voluntary sectors, negotiating clear roles and expectations, seeking diverse and flexible sources of funding, allocating sufficient and equitable resources, and communicating outcomes and impacts.

In conclusion, local mental health alliances can enhance financial security and sustainability by adopting a collaborative, inclusive, and strategic approach to funding and resourcing.

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