CENTRE FOR MENTAL HEALTH

Rethink Mental Illness.

# MORE THAN THE SUM OF OUR PARTS

An evaluation of local mental health alliances

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## ACKNOWLEDGEMENTS

We would like to express our sincere gratitude to all the colleagues from Rethink Mental Illness who supported this project in various ways. We appreciate the cooperation and assistance of the managers in the four sites: Coventry and Warwickshire, North East Lincolnshire, Sheffield, and Tower Hamlets. We also thank the colleagues in Rethink Mental Illness's national office for their guidance and feedback throughout the process. A special thank you goes to all the research participants, especially the experts by experience, who generously gave their time and shared their insights with us. Their contributions were invaluable. We hope that this report will help to inform and improve the practice and policy of mental health care in the UK and beyond.

# EXECUTIVE SUMMARY

Over the past three years, Centre for Mental Health has conducted a research project on the impact and groundbreaking potential of local mental health alliances led by Rethink Mental Illness in Coventry and Warwickshire, North East Lincolnshire, Sheffield, and Tower Hamlets.

Mental health alliances are collaborative efforts among various local stakeholders – such as VCSE organisations, NHS commissioners and providers of health and social care, and experts by experience – to provide support for people severely affected by poor mental health. These alliances work toward destigmatising mental illness, improving access to support and treatment, and encouraging innovation.

The research demonstrates that mental health alliances are essential for enhancing the quality and availability of mental health services and support. In each of the four sites we studied, the alliances have had significant impact on their local systems, from which many insights about cross-sector collaboration have emerged. Understandably, as the programme draws to a close, there is a fear that the systems will fall back into old patterns of working. Sustainable funding to build on what has already been achieved would be welcome.

The mental health alliances, which consisted of voluntary, community and social enterprise (VCSE) sector organisations, people with lived experience and other stakeholders, had some variations depending on local context, determined by historical events, cross-sector relationships, and system-wide willingness to change.

A survey of 70 respondents – partners, key stakeholders and experts by experience – showed that most organisations involved in the alliances had supported up to 1,000 people in the last 12 months, with most feeling that joining the mental health alliances had increased their reach. The alliances provided networking opportunities, strengthened working relationships, and increased their access to institutions and other stakeholders. They also enabled organisations to collaborate with more experts by experience – people who are experts in their own right due to their personal lived experiences, including caring experiences – and provided up-to-date information about local funding opportunities.

A number of key themes emerged from our analysis of consensus and divergence among the research participants, and these reflect the richness and diversity of their perspectives and experiences. They are summarised here:

- Responding to local context was crucial. For example, the VCSE sector faces multiple challenges, such as strong dynamics between providers, financial constraints, and a lack of coordination with other providers. These factors affected the quality and accessibility of mental health services for the diverse needs of people living with mental health problems.
- Clear and regular communication was essential in building trust and creating the conditions in which collaboration between VCSE sector organisations, experts by experience and other stakeholders could come to fruition.

- Initiating an alliance and maintaining momentum could be challenging, but clear assurances about the alliance's purpose helped keep focus and commitment. In North East Lincolnshire, for example, the alliance and its key partners worked hard to identify common ground and developed a shared understanding and vision for the work of the alliance.
- Trust was paramount for the success of the alliances and was the bedrock for meaningful collaboration. In Coventry and Warwickshire and Sheffield, the alliances encountered challenges from the existing system and prevailing service cultures. They focused on overcoming mistrust, promoted collaboration rather than competition, and showed how working together could reduce fragmentation within the sector and across different organisations.
- Taking enough time to build effective alliances – despite the urgency of the task and impatience to be effective – was crucial. Defining their focus in relation to service delivery was important and allowed for clarity about purpose and commitment.
- Coproduction with experts by experience was challenging but essential. Community engagement and open-door policies were key as they connected people and improved communication between services. In Sheffield, for example, there was a lack of consensus on what coproduction meant and how to practice it within the alliance. Alliance members worked together to agree their stance and optimise engagement of experts by experience and other participants.
- Alliances were able to effectively tackle broader issues such as eurocentrism and racism in mental health interventions, and help improve mental health outcomes and experiences for people from minoritised communities.
- Meaningful VCSE sector collaboration required financial backing to facilitate the engagement of smaller organisations in the alliances and to avoid them competing for the same funding sources.
- Successful collaboration relied on practical aspects such as sufficient notice for meetings, prompt minutes from meetings, and easy access to parking, meeting rooms, and meeting spaces.

At this critical juncture, when a new government is about to set the direction and priorities for health and social care, we offer five high-level recommendations that draw from the research. These recommendations provide a clear and compelling roadmap for policy makers and local systems leaders to follow in order to achieve a more effective and empowering mental health service landscape.

**Centre for Mental Health recommends:**

1. Integrated care boards (ICBs) should resource, develop, support and work with mental health alliances.
2. The Department for Health and Social Care (DHSC) should incorporate the core principles of mental health partnerships into the broader strategy for health and social care to establish a unified and clear vision for mental health.
3. NHS England should secure a binding commitment from ICBs to provide ongoing and sustainable resources for mental health alliances as part of a long-term funding plan for mental health initiatives. This could be achieved in future annual planning guidance and strategies following the Long Term Plan.
4. NHS England should encourage the development of networks of mental health alliances across all integrated care systems (ICSs), by issuing improved guidance around commissioning, working proactively with systems to reduce barriers to collaborative working, and introducing light-touch access to community mental health transformation funding for grassroots organisations.

5. NHS England should hold systems to account for implementing in full its existing statutory guidance for 'working in partnership with people and communities'.
6. The DHSC should establish a national evaluation and learning framework that comprehensively and independently assesses the impact of mental health alliances and suggests areas for improvement, while maintaining transparency and accountability at every stage, and use its findings to inform future policy making and practice.

# 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.

The evaluation questions focused on:

- How mental health alliances are formed and governed
- The benefits and challenges of working with 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.

## BACKGROUND

According to Rutter *et al*. (2012), local mental health alliances are partnerships or networks that bring together stakeholders with a common goal or interest within a specific area or in relation to a specific mental health issue. They can involve VCSE organisations, NHS providers, local authority departments, and experts by experience, such as people with lived experience of mental health problems, carers, and peer supporters. These alliances enhance the coproduction of services, boost the wellbeing of people with lived experience and carers, and innovate and achieve efficiency in service delivery.

A scoping review of literature on local alliances for mental health by Borghi *et al*. (2017) identified 35 studies from 11 countries, covering various types and levels of alliances. The main motivations it identifies for forming local mental health alliances 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. Their main outcomes and impacts are related to the improvement of service delivery, user and carer satisfaction, and population mental health and wellbeing.

## AN ALLIANCE OF ALL KEY PLAYERS

VCSE organisations play a key role in meeting the needs of people with mental health problems by offering a range of services and supports that complement or supplement those provided by the NHS. An example of such organisations designing and implementing innovative approaches to long-standing, complex problems is the Crisis Care Concordat, a national agreement between 27 organisations to improve the response to people in mental health crises (Centre for Mental Health and Rethink Mental Illness, 2018).

Crucial to the alliances, in addition to engagement of partner organisations across all sectors, is the structured and meaningful engagement of people with lived experience, often referred to as experts by experience. People with lived experience contribute to the planning, delivery, and evaluation of services, ensuring they are responsive to their needs and preferences. Their involvement can take various forms, such as consultation, co-production, co-design, or co-delivery (SCIE, 2015).

## PREVIOUS EXAMPLES OF MENTAL HEALTH ALLIANCES

There are a number of examples of local alliances for mental health from which learning can be drawn.

For instance, Gillard *et al*. (2017) conducted a qualitative evaluation of the Lambeth Living Well Network Alliance, finding that it improved service user experiences, increased collaboration and trust among partners, and promoted a recovery-oriented approach to care. However, they also identified some difficulties in aligning the different organisational cultures, values and practices of the partners, as well as ensuring adequate representation and engagement of service users and carers.

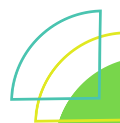
Similarly, Wright *et al*. (2016) analysed the Leeds Mental Health Framework, reporting that it enhanced service integration, reduced duplication, and increased efficiency and effectiveness. Nevertheless, they also highlighted some barriers to partnership working, such as conflicting priorities, power imbalances, and resource constraints.

Furthermore, Dowling *et al*. (2017) examined the Greater Manchester Mental Health and Wellbeing Strategy, showing that it fostered a shared vision and commitment among stakeholders, increased user and carer involvement, and improved mental health outcomes and inequalities. However, they also noted some challenges in achieving consensus, coordination, and accountability across the complex and diverse alliance.

## KEY CHALLENGES

One of the key challenges for local mental health alliances is to secure adequate, stable funding to support their activities and outcomes. According to Centre for Mental Health (2018), funding for mental health services has been disproportionately cut compared to other NHS services, leading to reduced access, quality, and choice for people with mental health problems. Moreover, the distribution of funding across different parts of the mental health system is uneven and inconsistent, creating gaps and inefficiencies in service provision.





Local mental health alliances therefore need to develop innovative and collaborative approaches to funding, such as pooled budgets, joint commissioning, social investment, or outcome-based contracts. These approaches can enable greater flexibility, efficiency, and accountability in the use of resources, as well as aligning the incentives and goals of different partners. For instance, pooled budgets involve the merging of funds from different sources or organisations to create a single budget for a specific service or population group.

## ACHIEVING SUCCESS

These approaches can help local mental health alliances overcome some of the barriers and challenges of traditional funding models, such as fragmentation, competition, or short-termism. However, they also entail risks and limitations, such as complexity, uncertainty, or unintended consequences. For example, pooled budgets may require complex governance and legal arrangements; joint commissioning may face uncertainty and resistance from stakeholders; social investment may entail high transaction costs and performance pressures; and outcome-based contracts may lead to 'gaming' or cherry-picking of service users or outcomes. Therefore, local mental health alliances need to carefully assess and manage the potential benefits and drawbacks of these approaches, as well as ensure transparency, participation, and evaluation of their funding processes and decisions (Borghi *et al*., 2017).

# HOW WE DID THE RESEARCH

To understand how these different approaches are implemented and experienced in practice, we conducted a mixed-methods evaluation in each of the four sites where Rethink Mental Illness had led the development and implementation of mental health alliances.

The research evaluated the following questions:

- How are mental health alliances formed and governed in each site? What are/have been the key drivers, enablers, and barriers for their establishment and functioning?
- How do VCSE organisations and experts by experience participate and contribute to the mental health alliances in each site? What are the benefits and challenges of their involvement and collaboration?
- How do the mental health alliances influence the provision and quality of mental health services and support in each site? What are the intended and unintended outcomes and impacts of the alliances for service users, carers, providers, and commissioners?
- What are the commonalities and differences between the mental health alliances in each site? What are the contextual factors, enablers and barriers, and other mechanisms that affect their development, performance, and sustainability?
- What are the key lessons and recommendations for developing and supporting mental health alliances in other localities and regions? What are the implications and recommendations for national policy and practice on mental health alliance building?

The researchers chose methods which allowed them to focus on what had been learnt in building and implementing local mental health alliances, as well as the strengths of the work undertaken in the sites. The research was primarily qualitative in its approach and data was collected and analysed through interviews, focus groups, observations, and document analysis. In the final stage, questionnaires were also used.

Baseline interviews were conducted with Rethink colleagues in local areas to explore their expectations, motivations, challenges, and opportunities for partnership working. Follow-up focus groups were conducted with stakeholders, including colleagues from partner organisations, and experts by experience, in each of the sites. They considered the progress, barriers and enablers, early outcomes, and impacts of the alliances, as well as the factors that facilitated or hindered their success. Thematic analysis was used to identify, analyse, and report patterns within data, providing detailed and nuanced insights. A cross-case analysis was conducted to compare the experiences and findings from the sites, and to identify the key lessons and recommendations for future practice and policy.

Data confidentiality and security were ensured through ethical and technical protocols, including informed consent, and data storage and destruction.

### TABLE 1: METHODS USED IN EACH PHASE OF THE RESEARCH

| PHASE | METHODS |
|---|---|
| **Phase One:** October 2021 to March 2022 | ◎ Regular meetings – scoping out evaluation and agreeing approach<br>◎ In-depth interviews with Rethink programme leads in local areas (North East Linconlshire, Sheffield, Coventry and Warwickshire, and Tower Hamlets) to gain in-depth understanding of local situation, challenges and solutions, and key learning points<br>◎ Familiarisation with each geographical area: desktop research, JSNAs<br>◎ Attendance at Rethink team meetings, advisory groups, workshops<br>◎ Immersion in policy analysis: understanding integrated care systems; coproduction; impact of the Covid-19 pandemic and associated restrictions on mental health<br>◎ A site visit to Warwickshire – took part in a coproduction event. |
| **Phase Two:** September 2022 to July 2023 | ◎ A series of online workshops, one in each site. 38 attendees – including voluntary sector colleagues, experts by experience and by training, and colleagues from statutory bodies – were selected and invited by local Rethink colleagues. They discussed at length their perspectives on progress to date, their expectations of the programme, and the learning so far. |
| **Phase Three:** December 2023 to June 2024 | ◎ Development of case studies based on the information collected by each of the site leads in close contact with the researchers. They each provided local context. Research participants described how the alliances operate locally and pulled out key learning points for future policy and practice<br>◎ Analysis of a questionnaire designed by Rethink that has been circulated to key stakeholders in each of the sites. |

Ethical considerations in research involving mental health focus groups and interviews were crucial for ensuring the protection of participants' rights, fairness, and impartiality. The researchers obtained consent from each of the participants and provided a clear rationale for the research. They also protected their privacy and confidentiality, ensured the safety and wellbeing of participants, and were mindful of the influence of relationships in local areas throughout the study.

# FINDINGS FROM THE RESEARCH

The research aimed to explore the experiences and perspectives of mental health alliance stakeholders in four sites, with a focus on the role of voluntary and community sector organisations and experts by experience. The findings from the research reveal some of the opportunities and challenges for improving mental health outcomes and collaboration across the system.

## HOW THE ALLIANCES OPERATE

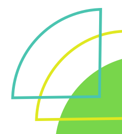
VCSE collaboration is vital to successful, system-wide efforts to improve mental health. However, impact has been blunted historically by competitive contracting environments that did not encourage working together. Collaboration, where it had been done well, also meant that experts by experience could be valued across the board, and sustainability and consistency could be embedded. However, capacity issues were key. With large organisations there is a built-in capacity for employees to go to events and attend opportunities which does not exist for smaller organisations. An ability to share this load makes local VCSE collaboration more impactful.

When, as a VCSE lead of a larger organisation in North East Lincolnshire noted, the "big funding potato" lands in local areas, it can become "a bit of a free for all" – but if local alliances can "find a way to work collaboratively and coproduce then that is the way to go". This allows them to concentrate on what organisations are good at doing and, as another noted, to "take the bit of the funding pie that is correct for them".

For several smaller organisations in North East Lincolnshire, the alliance has been "a huge support". For some, where there are only two employees, it has given them more time and helped them to avoid duplication, has given them support as individuals, and has provided help for people who spend a lot of time delivering services. Successful collaboration also depends on practical things such as plenty of "notice being given for meetings", "the minutes from meetings being really good and coming out quickly", "everyone being given the opportunity to input into the agenda, easily accessible parking, good meeting rooms and an easy place to get to for everyone".

Beyond the practicalities, research participants highly valued the way being part of an alliance helped them to understand the wider system. In bringing together organisations and colleagues who work on different parts of the pathway – prevention and early intervention as well as crisis and recovery – participants had a growing understanding of how local systems work and an appreciation of the actual and potential contribution of organisations in a transformed mental health landscape. However, this sometimes had a frustrating outcome when it laid bare the domination of clinical services and the lack of willingness on their parts to see the value that community-driven, non-clinical services could deliver. Rethink colleagues have also sought to engender a sense of belonging to the alliance, and a brand with which its members can identify as a means of keeping them engaged and motivated.





It is also important to note how dynamics in each area affected the quality of VCSE collaboration. The VCSE in Tower Hamlets, for example, faces challenges around forming strategic partnerships, innovating and being flexible, coping with financial challenges, engaging the community, and managing sector precarity. These factors affect how the sector operates. Coordination across VCSE provider organisations in Tower Hamlets is a challenge due to the diversity and complexity of the mental health needs in the borough, the fragmentation and variability of funding sources, and the lack of a shared vision and strategy among the stakeholders. This means that what successful collaboration looks like in each area varies, but allowing time for this collaboration to develop is key.

Finally, in our survey, many respondents felt the mental health alliances allowed "proper" collaboration to occur between organisations. Not only does this "improve communication" between partners, but importantly, there are more opportunities to "learn and share" resources and expertise with one another.

**Alliances should involve all their members in planning processes, and also use a participatory and evidence-based approach to measure and report on the outcomes and impact of their work. The successes in Coventry and Warwickshire came from the alliance's willingness to encourage all its members, including experts by experience, to engage.**

Case study: **Coventry and Warwickshire**

## DEVELOPING A SHARED UNDERSTANDING

Participants noted that, in the early stages, some organisations were able to come together to develop a vision for a local mental health alliance, while others were not. This has since become a source of tension for some, where subsequent developments have been seen as excluding smaller players. Indeed, some alliance members expressed disappointment. The expected advantages of being part of an alliance (notably in terms of resources and influence) had yet to be realised, despite them contributing significant time and effort.

Discussions from Sheffield demonstrated some of the challenges of starting an alliance. This included establishing what the alliance is, what it does and who will be involved. This was coupled with, as Rethink colleagues who were helping to establish the alliance told us, there being natural "suspicion about something new" before knowing what the alliance would develop into. To alleviate some of these fears, it was important for those establishing the alliance to reassure members that the alliance was "not meant to duplicate what exists but rather complement what is out there".

These early issues were also highlighted in North East Lincolnshire where the VCSE sector was facing a difficult situation and was eager to change for the better. However, they needed to overcome some obstacles, such as the lack of funding, collaboration and engagement. One of the ways to address these issues – promoted by Rethink colleagues – was to join the mental health alliance to improve the mental health services and outcomes in the region. Not all VCSE organisations were convinced of the benefits of the alliance, but through careful and dialogue and negotiation, alignment was found.

In Sheffield, the early stages saw several meetings and workshops to build the alliance and a vision which had the following objectives:

- A collective voice and influence for the sector
- A place to let off steam and find support
- A culture of collaboration and mutual support, rather than competition and fragmentation, to enable more effective coordination
- Increasing the access and availability of resources and funding
- Pooling and sharing assets
- Creating opportunities for joint bidding and commissioning.

The development of the vision in this area underscores the importance of taking time to carefully craft a shared understanding.

**Smaller organisations from the voluntary and community sector in Coventry and Warwickshire sometimes saw larger charities and statutory players as having power and resources, and felt intimidated, ignored, or threatened by them. The alliance strove to foster a more equal and respectful relationship between the VCSE and statutory sectors, and to advocate for more recognition of the voluntary and community sector's role and contribution to mental health.**

Case study: Coventry and Warwickshire

## THE ROLE OF TRUST

Trust between VCSE organisations and a willingness to collaborate are important factors and are often mutually beneficial. In this sense, the progress of the alliance is often evident where relationships are well developed and mature, and based on trust. However, where trust is limited, duplication can emerge, creating confusion for an already overstretched VCSE sector, whose capacity to engage in networks and alliances outside of their core functions might be limited.

The competitiveness which has been fuelled by a divisive approach to health and social care commissioning has, on occasion, left a legacy of mistrust amongst VCSE organisations, and fighting over small (but important) pots of money has been damaging. This must be kept in mind when alliances attempt to develop and build trust in local areas, recognising that this is not a quick win.

Time and again, participants in one-to-one interviews and in groups highlighted how success across the board required generous leadership, trust, and agreement about how the alliances would work and to what end, along with transparency about how decisions were made. Some research participants thought that decisions had, on occasion, been taken by Rethink colleagues without the involvement of local partners, and that posed a threat to the trust upon which the future of the alliance(s) relied.

Collaboration is also built through trust, and, in Coventry and Warwickshire, a colleague from a smaller VCSE organisation felt that they had "struggled to get a common set of values, beliefs, [and] ways of working and being inclusive", which had hindered the development of collaboration through trust. Perhaps one of the biggest issues is the feeling that mental health alliances are "being led by big powerhouses, where you [as a smaller VCSE organisation] then have less access; they make the decisions and there is a lot of talk but there is no action". A lot of this stems from distrust and it is important that the  big powerhouses' continue to make a genuine effort to devolve power and share it properly. These feelings were shared in each of the sites.

In Sheffield, when the alliance first started there was competition and fragmentation within the sector, which can hinder collaboration and coordination among different organisations. Building trust over time to overcome these barriers is central to any success.

**A strong commitment to coproduction – with experts by experience, experts by training, and others – has been fundamental to the programme's achievements in Coventry and Warwickshire, as the alliance has involved people with lived experience of mental health issues in all aspects of its work, from design to delivery to evaluation.**

Case study: **Coventry and Warwickshire**

To help us explore the extent to which organisations within the alliances were working in collaboration with one another, we asked respondents – stakeholders and experts by experience – in our survey to indicate the extent to which they agreed that coproduction (here meaning collaboration between organisations) had increased since joining the alliance. A total of 58 people responded, with over half (60.3%) stating that they 'agreed' or 'strongly agreed' that coproduction had grown after joining the alliance, 36.2% stating they 'neither agreed nor disagreed', and a minor proportion of 3.5% stating that they 'disagreed' or 'strong disagreed'. Our findings demonstrate that forming mental health alliances provides opportunities for organisations to work in collaboration with one another and increase chances of coproduction.

In addition, we asked the respondents to indicate the extent to which they agreed that their coproduced recommendations are often taken into consideration by local decision makers. A total of 37 people provided responses. While most respondents (52.4%) 'agreed' or 'strongly agreed' with the statement, 33.3% neither agreed nor disagreed, and a further 14.3% 'disagreed' or 'strongly disagreed'.

A small number of respondents highlighted the difficulty in reaching a consensus of the definition and suitable approaches to coproduction within the alliance. As one respondent shared, they felt that the term is "overused" and many people "don't really understand what [coproduction] means" which leads to irregular practices.

The above findings demonstrate that developing a shared understanding that is owned across organisations and genuinely coproduced is key to an alliance being successful in any area.

## HOW FAR DO THEY REACH?

In our survey, we also asked our respondents to indicate the number of people their organisation had supported in the last 12 months. Of the 70 respondents who completed the survey, 37 provided responses. Most of the respondents (64.9%) stated that their organisation had supported up to 1,000 people in the last 12 months. Around a quarter of respondents (24.3%) claimed that their organisation had supported between 1,001-5,000 people, while a small proportion of respondents (10.8%) worked in organisations that had supported more than 5,000 people in the last 12 months.

We asked our respondents whether they felt that joining a mental health alliance had increased their reach in support. From a total of 28 responses, 25% of respondents felt that being part of the mental health alliances had improved their reach to a 'great extent.' Conversely, 21.4% stated that the mental health alliances did not produce any noticeable difference in their ability to reach and support their community. Most respondents (53.6%), however, reported that joining the mental health alliances had improved their reach to 'a little' or 'some' extent. Our data suggests that while the mental health alliance may not make a significant difference in the organisation's reach in support of their communities, it had made a small to moderate difference for most respondents.

Additionally, we asked respondents to indicate whether working in the alliance had improved their reach with certain groups or communities. Of the 28 respondents who provided responses, 35.7% answered 'yes,' a further 35.7% answered 'no,' and the remaining 28.6% answered 'don't know.'

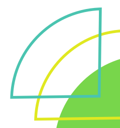
From those who indicated that working with the mental health alliance had increased their reach with certain groups, some key themes emerged. Many of the respondents noted that joining the alliances had widened their knowledge and awareness of the local services and different types of support available within their community. Having an improved "understanding [of] the bigger picture of what's going on in the mental health space" meant that those within the alliance could signpost to one another, allowing for a more "cohesive approach" to providing suitable care and support to their service users. This was especially beneficial for smaller organisations to gain exposure within their local area and to receive more support and guidance from the bigger, more established partners.

Some of the respondents shared that the alliances provide good networking opportunities for local organisations, which helped to strengthen working relationships, and "increased [their] reach to institutions and other stakeholders". One respondent further noted that working with the alliance had enabled their organisation to work with more experts by experience, which had been a "fantastic" addition to their work. Several respondents noted that the alliance had been useful in providing up to date information about local funding opportunities, which some organisations "wouldn't have known about otherwise". Two respondents noted that this was particularly beneficial for the smaller organisations who had "never received funding from the integrated care board".

## THE IMPORTANCE OF TIME

Our findings suggest that giving alliances the necessary time to develop was key to having any success. Time allows alliances and the VCSE organisations to establish clarity about purpose and levels of commitment at the preliminary stages and to negotiate terms of reference which has, on occasion, been challenging. All of this relies on compromise from those involved and this can be a difficult and timely objective to achieve.





We heard from participants involved in the alliances in Sheffield, North East Lincolnshire and Coventry and Warwickshire that time, patience, transparency and openness about processes is key. It takes a lot of time to build trust and belief "that this is not just another group". Furthermore, another VCSE colleague noted, "time is what people need to set these alliances up effectively". In Sheffield, a VCSE partner organisation told us that "they are set up for the right reason, but we need time and to be involved in conversations from day one". Ultimately, the concept is "wonderful", but "it is quick to break a system but a long time to rebuild it".

Further to this, working in complex systems can be frustrating because progress can be slow. However, as those working in these systems remarked, taking time to build relationships is critical: moving too quickly can create issues further down the line.

A challenge that has beset the alliances from the beginning and continues to do so is the limited time smaller VCSE organisations have to commit to "another alliance". Those sitting on the alliance need time to be convinced that the work here is valuable and, crucially, not a replica of what they are already doing.

In Sheffield, the alliance is investing in people with lived experience and immersing them in working groups where their voices are heard, and all documents are coproduced. Involving people with lived experience in the process of shaping the alliance means that "you are more involved in the way it is going to look, you will build trust and want to come back and be involved".

In Coventry and Warwickshire, the establishment of the alliance was, at times, met with resistance and barriers. Rethink colleagues working in the area found allies in some of the organisations who had had similar experiences and carved out a role for the alliance that is distinct to that delivered by other VCSE sector bodies. As part of this process, the alliance in this area developed a Multi-Disciplinary Team (MDT) that meets to address complex needs of patients and families. In coordinating care in this way, they are shaping how services join up and collaborate.

The local alliance in Coventry and Warwickshire has had to work hard to build the reputation of the programme, which was orientated to focus on collaborating with experts by experience and with organisations that are willing to cooperate. Through a grassroots approach and genuine coproduction, which is developed over time, this alliance is seeing success.

## EXPERTS BY EXPERIENCE AND COPRODUCTION

Our findings, across all sites, robustly demonstrated that any successful alliance has engaged with experts by experience throughout its entire lifecycle. This engagement is not piecemeal, or to tick a box. It is official and written into an alliance's terms of reference. It gives experts by experience continual opportunities to shape discussions and debates, and to influence system-wide and service-specific changes to help people with mental health difficulties.

Where there is a history of meaningful and sustained community engagement, local people and patients have been more willing to engage. In Sheffield, experts by experience are seen, by all those currently sitting on the alliance, to be "making the system simpler and smarter" by avoiding repetition and duplication, making resources go further. They are also bringing wisdom to conversations, a greater "hope for change", and grounding organisations in what is important to people with lived experience.

In terms of coproduction we found that, where alliances had been most successful, they had operated an "open door policy" founded on transparency, openness around processes and ensuring that there were "no stupid questions". This direct feedback from experts by experience is invaluable in forming recommendations going forward. The value of coproduction is in connecting people and improving communication between services. Coproduction with people with lived experience also ensures that services hear perspectives and innovative ideas that can create better pathways between services – this was evident in the alliance in Coventry and Warwickshire. In short, coproduction activity led to alliances being more successful because lived experience perspectives were useful and varied.

Experts by experience told us that being genuine partners in these alliances has been good for them. In North East Lincolnshire, experts by experience felt that to be part of the mental health alliance has been an opportunity for them to have a voice in the community, as well as in services and across the system. As one expert by experience noted: "Our nerves at our first meeting were dampened by the welcoming atmosphere and pure recognition that we should be a part of the mental health alliance. There are no barriers to us having a say and giving our thoughts and sharing ideas to help the collaboration".

It was felt by those involved that having lived experience adds a dimension when looking at the hidden problems people face when accessing mental health services. The experts by experience have been able to translate their perspective on challenges, and have been involved with people "very high up right down to the people on the ground doing the delivery with EBEs". This has created more collaboration around funding bids, distributed funding to all community groups, helped in dealing with prevention and spotting early signs of mental distress, and led to better work at crisis point.

What does this genuine engagement look like in practice? In North East Lincolnshire, for example, it is written into their terms of reference that if is a subcommittee is formed, at least two experts by experience must be in that group. The alliance wants experts by experience to feel that they are equal members and that their contributions are equally valued.

**The Mental Health Strategy in North East Lincolnshire is a remarkable achievement that demonstrates the power of coproduction with experts by experience. It reflects the needs and aspirations of service users and sets out a clear vision and roadmap for improving mental health outcomes. It demonstrates the value in being determined and in championing and implementing strategy, as well as sharing learning and best practice with other systems that want to adopt similar approaches.**

Case study: **North East Lincolnshire**

The question of how to develop and centre experts by experience is also critical for success. One of the key aspects of the mental health alliance in North East Lincolnshire is to ensure that the voice of service users is heard and respected. The alliance aims to involve experts by experience in the design, delivery and evaluation of the services. In this, the alliance will provide more person-centred and recovery-oriented care and enable service users to have more influence over strategic and delivery matters.

The systematic engagement of experts by experience, then, was clearly highlighted as an important and welcome element of the local programmes. However, some participants queried whether their engagement was always fully valued and were concerned about the sustainability of the models being developed.

Where experts by experience were supported and rewarded by Rethink rather than with other, embedded organisations, there was a risk that the resources to keep them engaged will end, that their contributions will not be sustained, and that holes will be left in the infrastructure, impeding longer-term change. For some participants, this was seen as an important consideration.

It must be acknowledged that developing a strong and well-trained team of experts by experience is not easy. Local leads noted that this requires resources such as funding, training, supervision, and support, which are often scarce or unavailable. It also requires overcoming some practical challenges, such as recruitment, retention, communication, and coordination between the different VCSE and local statutory providers.

Some respondents, including both experts by experience and VCSE colleagues, shared that there "is still a barrier for EBEs" as their work and input is often undervalued in comparison to that of professionals. As one respondent noted, experts by experience are "not taken seriously by many people" and coproduction practices often feel like a "box-ticking exercise where decisions have already been made".

Historically, we have seen that the involvement of service users and carers in the design, delivery, and evaluation of mental health services in the VCSE and the wider system is often limited or tokenistic, which reduces how responsive and relevant services are to the needs and preferences of the people they serve. The ambition with experts by experience is that this can be reversed in a genuine way. The evidence suggests that, where done properly, this is possible but work still needs to be done.

## THE VALUE OF SMALL ORGANISATIONS

It is the small organisations which make up the alliances that are the bedrock of this project's success. In several cases, small organisations felt as though their impact and influence had been enhanced by being involved with an alliance, while others felt that there was still work to be done for small organisations to be properly valued.

One participant in North East Lincolnshire noted that at the integrated care board and health care partnership level, for example, mental health alliance success now "allows us to attend these meetings and alter the way in which some of the bigger strategic decisions are made". To improve the mental health and wellbeing of young people, for instance, services can't operate only at an acute level or school level. They must involve charities and broader services that work with children and young people, too. Where done well, alliances are doing this – involving a broad church of small organisations that provide holistic, wrap around care to people with mental health difficulties.

However, smaller VCSE organisations across the board, and specifically in Coventry and Warwickshire, told us that they found commissioning was "not very creative", with "vested interests from larger organisations who want to ensure that their interests are primary". Instead, VCSE organisations would like to see the development of "collaborative commissioning" which is more creative and inventive, and works alongside VCSE organisations that have limited time and resources.

Organisations, particularly in Coventry and Warwickshire, wanted to see a much greater focus on collaboration and how this could ease the pressures currently faced by smaller local organisations.

Much of this was based around the idea that the interactions between 'bigger' and 'smaller' organisations (namely, those giving money away and those receiving the money) often felt very transactional and short term. Additionally, some survey respondents felt that smaller organisations had less influence and are not "really listened to" by others within the alliance.

This demonstrates that there is still work to be done to ensure that smaller organisations feel valued and 'seen' by the larger organisations, commissioners and funding bodies. It is crucial, not only for their own benefit, but also for the sustained success of the alliances, that the perspectives, efforts, and sentiments of these smaller entities become a more integral part of the strategy.

**To tap into the diversity and innovation of stakeholders across Sheffield, the Rethink Team actively sought out, and engaged with, groups and individuals who could offer new perspectives and ideas about the city-wide strategy and on mental health system transformation more broadly. This took a lot of time but was fruitful and created positive relationships. They identified and worked with organisations that shared their vision and values, while acknowledging that, for the alliance to be successful, it had to have a broad membership with diverse interests.**

Case study: **Sheffield**

## LONG-TERM AND SUSTAINABLE FUNDING

Funding was, unsurprisingly, the most frequently raised topic throughout our interviews, focus groups and survey. Local VCSE organisations are used to larger organisations, commissioners and funding bodies promising money that does not materialise. The funding for the alliances provided by the Charities Aid Foundation so far has been well received and has undoubtedly achieved good results. However, the local organisations and individuals we spoke to, without exception, stated that if funding were not guaranteed and secured longer term, local areas would "go back to square one".

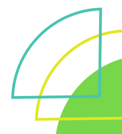
The funding pressures and uncertainties, especially as a result of Covid-19 and the cost-of-living crisis, remain unclear. This legacy also impacts staff sickness and their psychological wellbeing. Any long-term funding approach has to account for taking care of the staff providing these services.

There is significant anxiety in the sites about what will happen once Rethink Mental Illness's programmes come to an end. Opaque communications from statutory bodies about how much resource will materialise, and growing concerns about the future of alliances once the local programmes cease, also hinder trust. Clarity is being sought on who will take the lead, how the alliances will be funded, and what will be done to support engagement from the VCSE sector in a context of scarce resources and workforce depletion. This is a priority action as it will affect the survival of organisations working hard to deliver essential services.

In each of the sites, it was felt that organisations did not want to spend more time "speaking and being promised things that did not become realities". For some VCSE partner organisations in Coventry and Warwickshire, there were concerns that this comprised "more talking shops of the elite and less doing", and while "the intention from Rethink is right, there are cynical barriers that remain".

The funding for mental health services in the VCSE is often short-term, competitive, and uncertain, which creates instability and insecurity for the providers and limits their ability to plan, invest in capacity building, and collaborate with others. This is why it is more vital than ever to ensure that this programme does not fall foul of the same criticisms that have befallen previous attempts at building alliances in local areas.





## VSCE AND STATUTORY SERVICES WORKING TOGETHER

One of the strongest themes from our findings was the dominance of clinical services and medicalised views of mental health, which left community-based organisations at a disadvantage. However, when done well, alliances have created opportunities for members to meet experts by experience and others from public, VCSE and private organisations to explore real-life, contemporary challenges, and, together, identify future possibilities. Seeing the whole picture has been beneficial.

In Coventry and Warwickshire, some believed that too many mental health services are fixated on the medical model and not the community. VCSE organisations here told us that statutory services "think they are person-centred but they are intervention-centred and ignore the people that should be involved". As a result, the VCSE and statutory sectors are working in silos, and service users struggle to successfully move between the two. One expert by experience told us, "if you find yourself in a crisis situation and you are not a secondary care patient, you may struggle to get help".

In North East Lincolnshire, for example, their local Health Watch had "a foot in the statutory and voluntary [sectors], and the mental health alliance has drawn it all together". "Bringing prevention and early intervention and crisis together, brings it all together in the mental health space". Mutual respect is key here and makes experts by experience feel valued; the whole picture is seen as important, rather than any one individual. In North East Lincolnshire, those involved are all seen as equals and have an equal voice around the table.

However, it is important to remember that each local mental health alliance will have its own specific dynamics. This is where the importance of time, trust and collaboration become ever more important. When small VCSE organisations collaborate with statutory partners, they often encounter challenges such as:

- Stretching their scarce resources to cope with the growing need for mental health services
- Learning and adapting to the intricate health care systems and procedures of large NHS trusts
- Keeping their distinctive identity and approach while working towards the common goals
- Finding reliable sources of funding and staying financially viable in a challenging economic climate
- Acquiring the necessary skills and competencies to effectively work with large health care providers.

These difficulties demand strategic planning, clear communication, and strong partnership foundations. Where alliances have had success in terms of cross-pollination between the voluntary and statutory sector, VCSE organisations have felt heard. Alliances must focus on relationship building, not just between VCSE organisations but also with external statutory stakeholders. By providing physical spaces, mediated conversations and areas for collaboration, services are more likely to meaningfully work together and appropriately shift how mental health services work for those that need them.

## TACKLING RACISM THROUGH MENTAL HEALTH ALLIANCES

Tackling systemic racism is a key element in improving mental health, and demands close engagement with people from racialised communities. Issues relating to culture and language as well as mental health stigma need to be better understood. This is critical when engaging with VCSE organisations working with, and in, racialised communities.

**The deep structural challenges that VCSE and other organisations face in Tower Hamlets have deep roots and will not be resolved or solved easily. The local system learnt that it requires a long-term vision and commitment to address the root causes of health and social inequalities, such as poverty, racism, and discrimination, and to empower communities to have a voice and a stake in the system change.**

Case study: **Tower Hamlets**

There was a recognition, not least in Tower Hamlets and Sheffield, that issues of eurocentrism and racism in mental health services needed to be addressed. Racism causes trauma and damages mental health. It also stops people accessing services and securing help, as communities are fearful of how they will be treated. It is experienced in accessing mainstream services, where these are not culturally informed. It impedes recovery and leads to poorer outcomes. Participants drew attention to the deep inequalities experienced by people from racialised communities, and how organisations within those communities which directly addressed their needs had fewer opportunities for funding.

Racism in Tower Hamlets affects various aspects of community life (as it does in other areas). The borough has a history of racism that impacts public services and work opportunities. Deep consideration of these dynamics must be considered when establishing a mental health alliance, in any area.

However, these concerns were not only aired in Tower Hamlets. In Coventry and Warwickshire, one participant from a VCSE organisation spoke passionately about the potential for alliances to protect local systems against the same "white middle-aged people" always reviewing and writing the funding bids. Decolonisation of commissioning was discussed, and some participants queried whether proposed actions – such as diversifying the profile of people who assess bids and proposals – would yield the results they wanted to see, or whether this would be tokenistic.

**The mental health alliance in Tower Hamlets is aware of the relentless need to challenge the structural barriers and biases that prevent people from racialised communities from accessing its services. It has been reminded of the need to value the work of grassroots and community-based organisations that are often more responsive and effective in meeting the diverse needs of these communities.**

Case study: **Tower Hamlets**

# HOW TO IMPROVE THE ALLIANCES

In our survey, we asked the respondents to provide feedback on how the alliances could better serve the needs of people living with severe mental illness in their community. As the feedback from the four areas of intervention often overlapped, we summarise the overall key findings below.

## STRENGTHENING COLLABORATION

While some respondents acknowledged that a good level of collaboration exists with the alliance, there was a recurring theme across all interviews of the need for further improvement in this area. This included a need to improve the "presence" of experts by experience in the delivery of projects. As one person noted in North East Lincolnshire, the insights provided by experts by experience are invaluable, especially in terms of design and reach, as "people [living with] mental illness trust people that have [experience of] mental illness". However, this is not always acknowledged by all professionals, and thus it is crucial to encourage all organisations to actively work alongside experts by experience, to "listen to their voices" and "learn from those using their service" to improve support within their community.

Several respondents – at least one in every area – suggested that the alliance would benefit from developing a deeper understanding of the needs and "local dynamics" of the area. This could be achieved through increased "local visit[s]" and "one-to-one support check-ins", which would enable partners to "see what is going on on the ground level in different organisations representing different communities". Respondents repeatedly highlighted the benefits of collaboration between partners in the alliance, such as an improvement in signposting and increased opportunities to work with "like-minded organisations". However, there are suggestions that some members of the alliance may be working in "silos", which reduces the chance for collaboration. As such, it is important for the alliance to "strive to be fully inclusive" and ensure that "the coproduction model" is practised by all partners in the development and delivery of services.

## ORGANISATIONAL IMPROVEMENTS

Many of our respondents provided feedback on how the structure and functioning of the alliance could be improved to better serve the needs of their community. A repeated theme related to the tendency within some organisations to "focus on the general population" and adopt a "universal" approach to its provision of support. However, as one VCSE colleague highlighted, "one size does not fit all". Colleagues in workshops highlighted the need for more conversations about how to tackle barriers to access for "small, but high-need populations". They identified gaps within existing services and mapped out support pathways as ways to better serve the needs of people from minoritised communities.

A large proportion of respondents shared that the alliance would benefit from having a "wider variety of organisations" that vary in size and expertise. Some suggested that conversations are often "dominated by very large charities", with smaller organisations feeling like "second rate partner[s]". Thus, more work is required to create a safe, inclusive work environment for all members of the alliance to ensure that all contributions are "validated and taken seriously", regardless of organisation size and experience.

Several respondents thought that the functioning of the alliance could often be disorganised and unproductive. As two respondents shared in different sites, many meetings are of "dubious value" and would benefit from having meaningful agendas and appointing a "strong chair to lead" future conversations. Additionally, more discussions could be held for members to reach a consensus about the future ways of working for alliances.

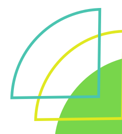
Finally, it was widely suggested that alliances' current focus on "serious mental health" may be exclusionary to those who do not have a formal mental health diagnosis or are deemed as "low-level" cases. As one expert by experience noted, the term 'serious' is "subjective and medicalised" and some people actively "avoid a medical diagnosis and label". As such, it is worth considering shifting the focus away from 'serious' mental health and instead becoming, as another expert by experience noted, more "open to mental distress without diagnosis and labels" to ensure holistic and inclusive care.

## ADDITIONAL FUNDING

A large proportion of respondents stressed the need for more "realistic" funding to enable more coproduced work to be conducted in the alliance. Several respondents highlighted the difficulty in receiving funding, stressing that the "increasing challenge of funding for VCSE organisations... through discussion with [the] ICB", and "power dynamic" between organisations and the NHS must be addressed. Although one respondent acknowledged that "some funding has been made available", the impact of such opportunities was limited as "it has only assisted a few organisations", and thus "no meaningful difference" has been made.

For the alliance to better assist the functioning of partner organisations, some respondents reported a need for more support to evidence their "value and models of working" to the ICB. Importantly, more effort and work are required to "get the NHS to listen to members [of the alliance], so they understand the need for funding [and] resources" for the continued development of the VCSE sector.





# WHAT MAKES A SUCCESSFUL ALLIANCE?

Collating insights from the study's participants regarding the critical factors for alliance success, the following observations were noted.

Good governance, planning and a local focus are critical to the success of the alliances. This means that alliances should be responsive to the specific needs, challenges and opportunities of their communities, rather than following a one-size-fits-all approach. They should also have clear goals, roles and responsibilities, and mechanisms for monitoring and evaluating their impact.

**Another key principle was to foster a culture of trust and accountability among system partners. The Rethink team achieved this by establishing clear and transparent governance structures, roles and responsibilities, decision-making mechanisms, and communication channels. They regularly reviewed and revised these arrangements as their work evolved and new challenges emerged. This enabled them to work effectively and efficiently with each other and with other system partners, and to avoid duplication or confusion of efforts.**

Case study: **Sheffield**

Inclusivity is key. Alliances should strive to represent and engage with the diverse perspectives of people with lived experience of mental health difficulties, as well as those who are often marginalised or excluded from mainstream services, such as people from racialised communities, refugees, LGBTQ+ people, young people, older people, and people with disabilities. They should also foster collaboration and partnership among different types of organisations, such as grassroots groups, advocacy groups, service providers, research institutions, and public sector agencies.

Offering a listening ear and guidance is crucial. Alliances should create a safe and supportive space for people to share their stories, experiences, opinions and ideas, without fear of judgment, criticism or stigma. They should also provide guidance and advice on best practices, funding opportunities, policy developments, and other relevant topics, while respecting the autonomy and diversity of the members. Finally, they should encourage honesty and transparency in communication and decision making and address any conflicts or challenges that may arise in a constructive, respectful way.

Keeping the mental health alliance the right size is key, as is enabling everyone to have a voice. Alliances should balance the benefits of having a large and diverse membership with the challenges of managing a complex and dynamic network. They should also ensure that all members have equal opportunities to participate and contribute to activities and influence the agenda, and that their views and interests are fairly represented and acknowledged. Critically, they should also avoid becoming unnecessarily hierarchical, and maintain a flexible, agile structure that can adapt to changing circumstances and needs.

Good terms of reference which include experts by experience are important. Alliances should establish clear and comprehensive terms of reference that outline the purpose, vision, values, objectives, scope, membership, governance, operations, and expected outcomes. The terms of reference should also include explicit provisions for the involvement and equipping of experts by experience. Terms of reference should specify how experts by experience will be recruited, supported, remunerated, and consulted throughout the alliance's work, and how their feedback and input will be integrated and acted upon.

# CONCLUSIONS

Having explored the challenges and opportunities of forming and sustaining effective mental health alliances, we can now draw some key lessons and recommendations for current and future practice.

We have found that, when done well, the alliances' purpose is twofold: improving the mental health of local people, and building the sustainability of the VCSE sector for the future.

These achievements can improve the quality and impact of the services delivered by the VCSE sector, by facilitating learning and knowledge exchange, and sharing good practice and innovation.

**Under the auspices of the strategy, the alliance has influenced a range of projects and collaborative approaches to address emerging needs such as post-Covid mental health support, children's mental health, measures to prevent early mortality, and suicide prevention.**

Case study: **North East Lincolnshire**

Understanding the dynamics between organisations is important. Within this, several broad actions are key, regardless of location. This includes developing a common framework and platform for the VCSE sector providers to coordinate their efforts, share best practices, and monitor their impact on the mental health of the population.

The hope is that the alliance improves communication and integration between the VCSE sector providers and other sectors, especially the NHS, which will help ensure seamless mental health services.

However, work remains. Some respondents to our survey shared that their coproduced recommendations are yet to be implemented, making it difficult to believe that their "feedback… and reflections" were truly considered by local decision makers.

Our findings suggest that the mental health alliances are, at present, adding value to their local areas and the ways in which VCSE sector organisations work. However, it is now that the 'real' work starts, and Rethink Mental Illness have taken ambitious steps to support future efforts. Ensuring that there is enough funding and time to continue this growing work will be the difference between success and failure for these mental health alliances. The key focus is now on sustainability and building infrastructure.

The local alliances have had success in several instances; in others, work remains. There are several key findings that we conclude can give a local mental health alliance the greatest chance of success.

## OUR KEY LEARNINGS

**A shared vision:** Having a shared and aspirational vision that is co-created by all the stakeholders, including the VCSE sector and people with lived experience. This vision should inspire hope, optimism, and confidence in the possibility of improving mental health outcomes for the community.

**Coproduction:** Engaging in a collaborative process that values the expertise and contributions of everyone involved, especially those with lived experience. Coproduction should be embedded at all levels of a local alliance, from strategic planning to service delivery, and should foster mutual respect, trust, and accountability among the partners.

**Willingness to learn and innovate:** Being open to trying new things, learning from mistakes, and adapting to changing circumstances. Local alliances should embrace a culture of continuous improvement and reflection, and seek feedback from the users and providers of the services. They should also be willing to challenge existing norms and practices that may hinder the recovery and wellbeing of the people and communities they serve.

**Healthy and progressive relationships:** Developing and maintaining positive and supportive relationships among alliance members, based on honesty, transparency, and collaboration. Alliances should also cultivate a sense of belonging and identity among the participants and celebrate their diversity.

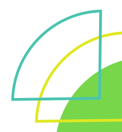
**Appropriate pace:** Setting realistic and achievable goals and timelines for the alliance, and allowing sufficient time for planning, implementation, and evaluation. Local alliances should also respect the different capacities and needs of the partners, and avoid putting undue pressure on them. They should balance the urgency of addressing local mental health needs with the patience and flexibility required for coproduction and innovation.

**Equitable voices:** Ensuring that all the voices and perspectives of alliance members are heard and valued, and that no one is marginalised or excluded. Alliances should also demonstrate humility and acknowledge that they do not have all the answers, and that they are willing to learn from others, especially those with lived experience. They need to be mindful of the power dynamics and potential conflicts that may arise among partners, and address them in a respectful, constructive way.

**Space for co-existence:** Creating a space where experts by training and experts by experience can co-exist and complement each other, without undermining or competing with each other. Alliances should recognise the unique and valuable contributions of both groups and support their collaboration and mutual learning. They should also promote approaches that respect the choices and preferences of individuals with lived experience and support their personal growth and development.

**Sustainability:** Securing long-term, stable funding for alliances and ensuring their financial viability and accountability. They should also develop a clear strategy for their sustainability, and identify the indicators to monitor and evaluate its progress. They should also seek to diversify their sources of funding and leverage the existing assets and resources of the community.





# RECOMMENDATIONS

The proposed recommendations are not standalone measures, but pivotal components of a comprehensive strategy aimed at transforming service delivery. This ambitious plan is anchored in financial support for the VCSE sector, a revitalised commitment to engaging individuals with lived experience, and the mobilisation of community assets to assist people with mental health difficulties.

By embedding coproduction, network governance, and recovery-focused methodologies at the core of mental health alliances, we advocate for a paradigm shift to service models that are not only reactive but also empowering. We call for a transition from conventional, hierarchical frameworks to ones that are cooperative, inclusive, and conducive to personal growth, thereby amplifying the contributions of all stakeholders, including the VCSE sector and people with lived experience. Through this approach, we aim to leverage the collective power of communities and the profound insights of those with lived experience to foster an environment that is both restorative and transformative.

At this critical juncture, when a new government is about to set the direction and priorities for health and social care, we offer five high-level recommendations that draw from the research. These recommendations provide a clear and compelling roadmap for policy makers and local systems leaders to follow in order to achieve a more effective and empowering mental health service landscape.

**Centre for Mental Health recommends:**

1. Integrated care boards (ICBs) should resource, develop, support and work with mental health alliances.
2. The Department for Health and Social Care should incorporate the core principles of mental health partnerships into the broader strategy for health and social care to establish a unified and clear vision for mental health.
3. NHS England should secure a binding commitment from ICBs to provide ongoing and sustainable resources for mental health alliances as part of a long-term funding plan for mental health initiatives. This could be achieved in future annual planning guidance and strategies following the Long Term Plan.
4. NHS England should encourage the development of networks of mental health alliances across all integrated care systems (ICSs), by issuing improved guidance around commissioning, working proactively with systems to reduce barriers to collaborative working, and introducing light-touch access to community mental health transformation funding for grassroots organisations.
5. NHS England should hold systems to account for implementing in full its existing statutory guidance for 'working in partnership with people and communities'.
6. The DHSC should establish a national evaluation and learning framework that comprehensively and independently assesses the impact of mental health alliances and suggests areas for improvement, while maintaining transparency and accountability at every stage, and use its findings to inform future policy making and practice.

# REFERENCES


Borghi, J., Le Meur, N., & Scior, K. (2017) Local alliances for mental health: scoping review of literature. *International Journal of Mental Health Systems*, 11(1), 13. DOI: 10.1186/s13033-017-0120-5

Centre for Mental Health and Rethink Mental Illness (2018) Crisis Care Concordat: Improving the response to people in mental health crises. Unpublished.

Centre for Mental Health (2018) Funding Mental Health Services: A Literature Review. Unpublished.

Dowling, B., Powell, M., & Glendinning, C. (2017) Conceptualising successful partnerships. *Health & Social Care in the Community*, 25(1), 38-48. DOI: 10.1111/hsc.12289

Gillard, S., Simons, L., Turner, K., & Lucock, M. (2017) Patient and public involvement in the coproduction of knowledge: Reflection on the analysis of qualitative data in a mental health study. *Qualitative Health Research*, 27(13), 2119-2130. DOI: 10.1177/1049732317728050

Rutter, D., Manley, C., Weaver, T., Crawford, M., Fulop, N., & Tyrer, P. (2012) Local mental health networks: implications for the NHS and third sectors. *Health & Social Care in the Community*, 20(3), 299-308. DOI: 10.1111/j.1365-2524.2011.01036.x

Social Care Institute for Excellence (2015) Co-production in social care: What it is and how to do it. Available from: **https://www.thinklocalactpersonal.org.uk/_assets/COPRODUCTION/Co_production_what_it_is_and_how_to_do_it.pdf** [Accessed 4 July 2024]

Wright, N., Rowley, E., Chopra, A., Gregoriou, K., & Waring, J. (2016) From admission to discharge in mental health services: A qualitative analysis of service user involvement. *Health Expectations*, 19(3), 629-641. DOI: 10.1111/hex.12376

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Published July 2024

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