Integration of Health and Social Care:

A case study of a London Borough.

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DECLARATION

I certify that the work contained in this thesis, or any part of it, has not been accepted in substance for any previous degree awarded to me or any other person, and is not concurrently being submitted for any other degree.

I also declare that the work contained in this thesis is the result of my own investigations, except where otherwise identified and acknowledged by references. I further declare that no aspects of the contents of this thesis are the outcome of any form of research misconduct.

I declare any personal, sensitive or confidential information/data has been removed or participants have been anonymised. I further declare that where any qualitative responses of participants are recorded/included in the appendices, all personal information has been removed or anonymised. Where University forms (such as those from the Research Ethics Committee) have been included in appendices, all handwritten/scanned signatures have been removed.

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DEDICATION

I dedicate this thesis to my late mum, for her great role in my life and her numerous sacrifices for me. She has been showering blessings from heaven and the short period I spent with her inspired me to work hard to achieve what I have in life. An admirable person that I miss every day. I will always remember the days we spent together. This one is for you, Umma, and I will always love you.

ABSTRACT

Background: There have been ongoing efforts in England to combine the NHS with local authority social care services to enhance health and wellbeing. However, research into integrated care in mental health provision remains scarce.

Aim: This qualitative case study aims to explore and examine the processes implemented for facilitating integration of health and social care provision in mental health in one London borough, where *The Collaborative* was established in 2010.

Methods: A case study methodology was adopted with a qualitative inductive inquiry based upon the paradigm of social constructionism. Method triangulation was employed by integrating data from the local documents including policies in phase one; 13 semi-structured interviews with a leadership team in phase two and five focus groups, each with four front-line staff in phase three. Four focus groups were conducted online due to COVID-19 and one in person. The policy analysis matrix was used for the documentary analysis and for subsequently identifying, refining, and connecting the emergent themes utilising NVivo 11. The data were analysed through thematic analysis.

Findings: The principles of collaboration, peer support and empowerment underpin the partnership between the five organisations under *The Collaborative* and the multidisciplinary team, including input from the voluntary sector. Implementation of these has achieved better access to housing for the service users. Inequalities, such as parity of esteem, socio-economic factors, ethnic minorities and stigma, continue to hamper access to mental health services and psychological support. The interviewees revealed that people with lived experience have benefitted from peer support and, during COVID-19 with digital peer support.

Conclusion: The findings indicate that *The Collaborative* is still developing. This study adds to the literature related to policy development in integrated care and mental health in a London borough with an ethnically diverse setting.

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TABLES

ABBREVIATIONS

ACT	Assertive Community Treatment
A and E	Accident and Emergency
AHC	Academic Health Centre
ART	Alliance Rehabilitation Team
BAME	Black Asian and Minority Ethnic
BHIMC	Behavioural Health Integration in Medical Care
BME	Black and Minority Ethnic
CA	Collaborative Alliance
CAGE	Cut-down, Annoyed, Guilty, Eye-opener
CAT	Competency Assessment Tool
CBC	Community-based Care
CC	Collaborative Centres
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CH	Collaborative Hub
CLT	Collaborative Leadership Team
CMHC	Community mental health Centre
CMHTs	Community Mental Health Teams
CO	Collaborative Outcomes
COD	Co-occurring mental health and substance use disorders
COS	Charity Organisation Society
COT	Community Options Team
COVID-19	Corona Virus Disease 2019
CQC	Care Quality Commission.
CQUIN	Commissioning for Quality and Innovation
CR	Crisis Response
CT	Collaborative Thrive
CV	Curriculum Vitae

DSRIP	Delivery System Reform Incentive Payment
DWP	Department of Work and Pension
EEC	Emotional Emancipatory Circles
EEI	Employment, Education and Information Unit
ePJS	Electronic Patient Journey System
FQHC	Federally Qualified Health Centre
FTE	Full-Time Equivalent
GIS	Geographical Information Systems
GMCA	Greater Manchester Combined Authority
GP	General Practitioners
HASCC	Health and Adult Services Scrutiny Committee
HIP	Health Improvement Profile
HM Government	Her Majesty's Government
IA	Integration Alliance
IAPT	Improving Access to Psychological Therapies
ICO	Integrated Care Organisations
IDDT	Integrated Dual Disorders Treatment
IMCC	Integrated Multidisciplinary Collaborative Care
IPS	Individual Placement and Support
IT	Information Technology
JP	Jobcentre Plus
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LB	London Borough
LCN	Local Care Networks
LGA	Local Government Association
LMIC	Low- and Middle-Income Countries
LSP	Local Strategic Partnership
MH	Mental Health
MHaPP	Mental Health and Poverty Project

MHCA	Mental Health Care Act
MHIS	Mental Health Investment Standard
MHIP	Mental Health Integration Programme
MHN	Mental Health Nurse
MHS	Mental Health Service
MHSW	Mental Health Social Workers
MS Teams	Microsoft Teams
NHS	National Health Service
NHS-MHS	NHS Mental Health Services
ODS	Organised Delivery Systems
PAG	Provider Alliance Group
PBHCI	Primary and Behavioural Health Care Integration
PHQ	Patient Health Questionnaire
RAID	Rapid Assessment, Interface and Discharge services
RCN	Royal College of Nursing
REFINEMENT	REsearch on FINancing systems' Effect on the quality of MENTal health care
RT	Rehabilitation Team
SAMHSA	Substance Abuse and Mental Health Services Administration
SCIE	Social Care Institute for Excellence
SEL STP	South East London Sustainability and Transformation Plans
SES	Socio Economic Status
SMI	Serious Mental Illness
SMS	Shared Measurement System
SOCC	Shifted Outpatient Collaborative Care
SPA	Single Point of Access
SSIF	Semi-structured Interviews Findings
SSM	Supported Self-Management
STP	Sustainability and Transformation Plans
SU	Substance Use

SUD	Substance Use Disorders
SUSTAIN	Supporting Seniors receiving Treatment and Intervention
TSO	Third Sector Organisations
UK	United Kingdom
UREC	University Research Ethics Committee
USC	Usual Source of Care
VCS	Voluntary and Community Sector
VCSE	Voluntary, Community and Social Enterprise
WEFORUM	World Economic Forum
WHO	World Health Organization
WHODAS	World Health Organization’s Disability Assessment Scale

CHAPTER 1: INTRODUCTION

Bringing health and social care services together has long been government policy (Department of Health and Social Security, 1973; Department of Health, 1998, 2006a). Joining services related to health with social services can be claimed to be more economic, lead to greater efficiency and effectiveness, and offer improved outcomes for service users (Frost, 2005; Glasby and Dickinson, 2014). However, these benefits are not without problems (Cameron and Lart, 2003; Peck et al., 2008; NHS Confederation, 2010).

Since the 1990s, there have been ongoing efforts in England to combine the National Health Service (NHS) with local authority social care services to enhance health and social care (Bogg, 2008; Local Government Association, 2017). To this end, many people have assumed that through creating multidisciplinary teams with representatives from various professional health and social care fields, it would be possible to give people in need a single access point to a wide range of skills and knowledge no one system could provide alone (Cooper, 2017). Also, integrated services are more effective in meeting the healthcare needs of patients, and addressing the economic issues stemming from austerity, such as limitations in health coverage, the restriction of access to treatment, and rising unemployment, poverty and homelessness.

Since 1997 (Department of Health, 1998, 2006a, 2008a, 2011, 2013), the topic of integrated health and social care work has been a key feature in policy and strategy documents, and there has been a lot of literature on the advantages of integrated working:

'…integrated services are much more likely to improve people's health and wellbeing in ways which treat them with dignity and respect, and it makes financial sense to get rid of duplication and waste' (Local Government Association, 2013: p1).

1.1 Why Integrate?

The health care system has always been dependent on social care. Demographic trends, however, have made integration between the two areas of care increasingly relevant. People in the prime of their lives make up a greater percentage of the population now than they have in many decades. Over the next several decades, it is predicted that this tendency will continue (Office of National Statistics, 2015). Some of the impacts of an ageing population on the provision of health and social care services are outlined in the 2014 interim report of the commission on the Future of Health and Social Care in England (known as the 'Barker Commission'). According to the projections, in the coming years, the numbers of elderly people will greatly exceed previous forecasts, resulting in a significant rise in the number of fragile older adults who have various ailments that need either medical or social care. Additionally, due to an increase in life expectancy, there has been an increase in the number of elderly individuals who suffer from the so-called illnesses of old age, such as Alzheimer's disease and Parkinson's disease. These diseases might often require social assistance alongside medical treatment (Barker, 2014). Supporters of integration also contend that integration saves the NHS and local governments money. The 2014 interim report has stated that, based on current data, 20 percent of acute hospitalisations are unnecessary, and it is possible to provide superior medical treatment in other locations, such as at home. This level of care will rarely cost less, though it may on occasion. Integration between primary and secondary care and plans for end-of-life care will either prevent or allow for earlier release after treatment is completed.

It is unclear in the research if integrated working is advantageous for service users or employees working in such services (Dickinson et al., 2013). The suggestion will be made that although integrated working has featured heavily in policy and strategy documents, research papers and publications for some time, little progress has been made, and there is conflicting evidence on how well integration works (Leutz, 1999; Shaw and Levenson, 2011) and on the service user outcomes (Silva, 2011).

1.2 Integrated Care in Mental Health

A significant goal in England is the creation of integrated approaches to mental health. When it comes to people's mental health, their medical treatment typically exists in a separate healthcare system from the wider health and care system, which means that individuals are not always provided with coordinated support to meet their physical health, mental health, and social requirements. This research on *The Collaborative* has identified several long-standing issues that had previously gone unnoticed by the 'business as usual' method of operation: extremely poor service user experience and lack of an integrated care pathway, high caseloads in secondary care services and reduced hospital budget allocation.

In recent years, the care of people with serious mental illness has been the subject of continual policy innovation that has sought to support the transition of care by institutions to care in the community through the emergence of an integrated approach to the delivery of services. This integrated care of people with serious mental health has come to particular prominence following a number of high profile incidents, which have, following several reports (for example, Ritchie, Dick and Lingham, 2014), led to some severe criticism of mental health service provision in the United Kingdom (UK). In addition, people with mental health are one of the most disadvantaged groups within society, and the nature of their illness requires long-term intervention to meet a range of complex health and social care needs (Public Health England, 2018). The provision of integrated care is considered a key feature in meeting these needs.

Due to legislative measures passed under the Health Act 1999 (Section 31) and the National Health Service Act 2006 (Section 75), local authorities have transferred responsibility for social care, which has resulted in them delegating social work duties to local authority social workers and then passing their mental health services work to NHS mental health services (NHS-MHS) to form multidisciplinary teams. One of the leading causes of disability in the UK is mental health disorders. Approximately nine out of every 10 persons with mental health difficulties have a primary care provider who helps them. To help people with severe mental illness, new and integrated forms of primary and community mental health treatment are also being created. Crisis cafés, sanctuaries and safe havens deliver a more acceptable alternative to the Accident and Emergency (A and E). Services of this type are prevalent in several industries. With lower prices and a higher level of customer satisfaction, integration of resources has provided more effective care for those in mental health crises (NHS England, 2019). A greater integration of services across the NHS, the voluntary sector, and the Local Authority (LA) has allowed for more effective care for people in mental health crises (NHS England, 2019).

Examples of NHS England's integrated support initiatives include mental health liaison services in acute hospitals, integrated perinatal mental health care, psychological therapy services for people with long-term conditions, and improved access to physical health assessments for people with severe mental illnesses (NHS England, 2016). For anyone in Cambridgeshire and Peterborough experiencing a mental health crisis, a community-based mental health crisis First Response Service (FRS) has been established (NHS England, 2016). Prior to the service's launch, there was no option for persons in need of mental health care outside of normal business hours, other than going to A and E. Moreover, there was no self-referral option, so many people went to A and E for treatment. In addition to accepting self-referrals as well as urgent referrals from care providers, General Practitioner (GP)s, ambulance crews, police, and the emergency department, the FRS is available 24 hours a day, seven days a week.

Frimley Health and Care opened the Aldershot Safe Haven Café to provide persons in mental health crisis or at danger of developing a crisis with an alternative to going to A and E (NHS England, 2016).

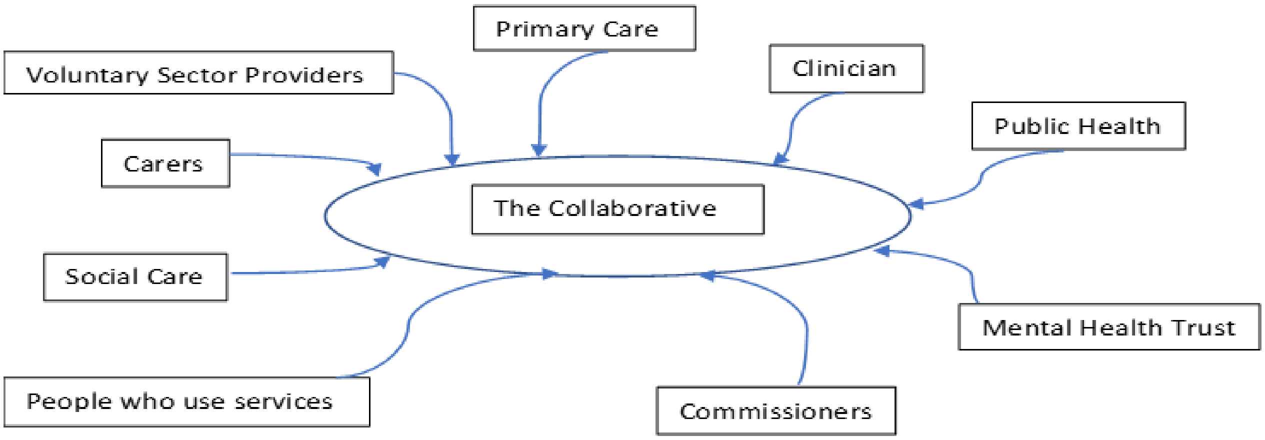
Every day and night of the year, the cafe is open to help customers avoid having to use the NHS for urgent care. There are psychiatric nurses and other mental health specialists on hand to aid those in crisis, as well as those at risk of social isolation, to maintain their mental health. The impetus for this research arose from the realisation that there was a lack of depth in what was known about the different integrated care programmes in place for mental health provision.

1.3 Research Setting

This research was conducted in a London borough. The researcher was the Chair of Health and Wellbeing board in a London borough. At London Council's, London Health and Wellbeing Board Chairs' Network meeting, researcher had the opportunity to connect with the other chairpersons of Health and Wellbeing boards of London boroughs. One of the chairs was from the research borough. The researcher met the Chair of the research borough for the first time. During the updates from the London boroughs, the researcher learnt about the research borough's integration agenda and that *The Collaborative* is an entity, established for over 10 years within that borough. The researcher had further discussion with the Health and Wellbeing board Chair of the research borough and was introduced to the gatekeeper, who was the Assistant Director of Clinical Commissioning Group (CCG) in the local authority where the study was conducted. The gatekeeper introduced the researcher to the monthly breakfast meetings, the leadership team and some of the front line staff. Accessing the London borough and gate keeping will be explained in detail in the Methodology chapter in section 4.4.1.

The council and CCG were open to new experiences, and the providers were willing to collaborate, proving the strength of their partnerships. The story goes back to June 2010 with the CCG forming *The Collaborative*, comprising local stakeholder groups such as service users, caregivers, voluntary sector providers, commissioners, and those involved in primary care, social care and secondary care (Figure 1.1). *The Collaborative* started meeting monthly for breakfast. The meetings were in a local café which provides training and employment for people who have experienced adversity. The breakfast meetings continue to this day and during the COVID-19 pandemic the meetings were held remotely. Over the years, the group has created new ways of working, peer support, crisis lines and new employment and financial advice services. They also host events to hear from people about what would make services better.

Figure 1.1 ***The Collaborative*** **(Adapted from Together Transition Programme (2017))**

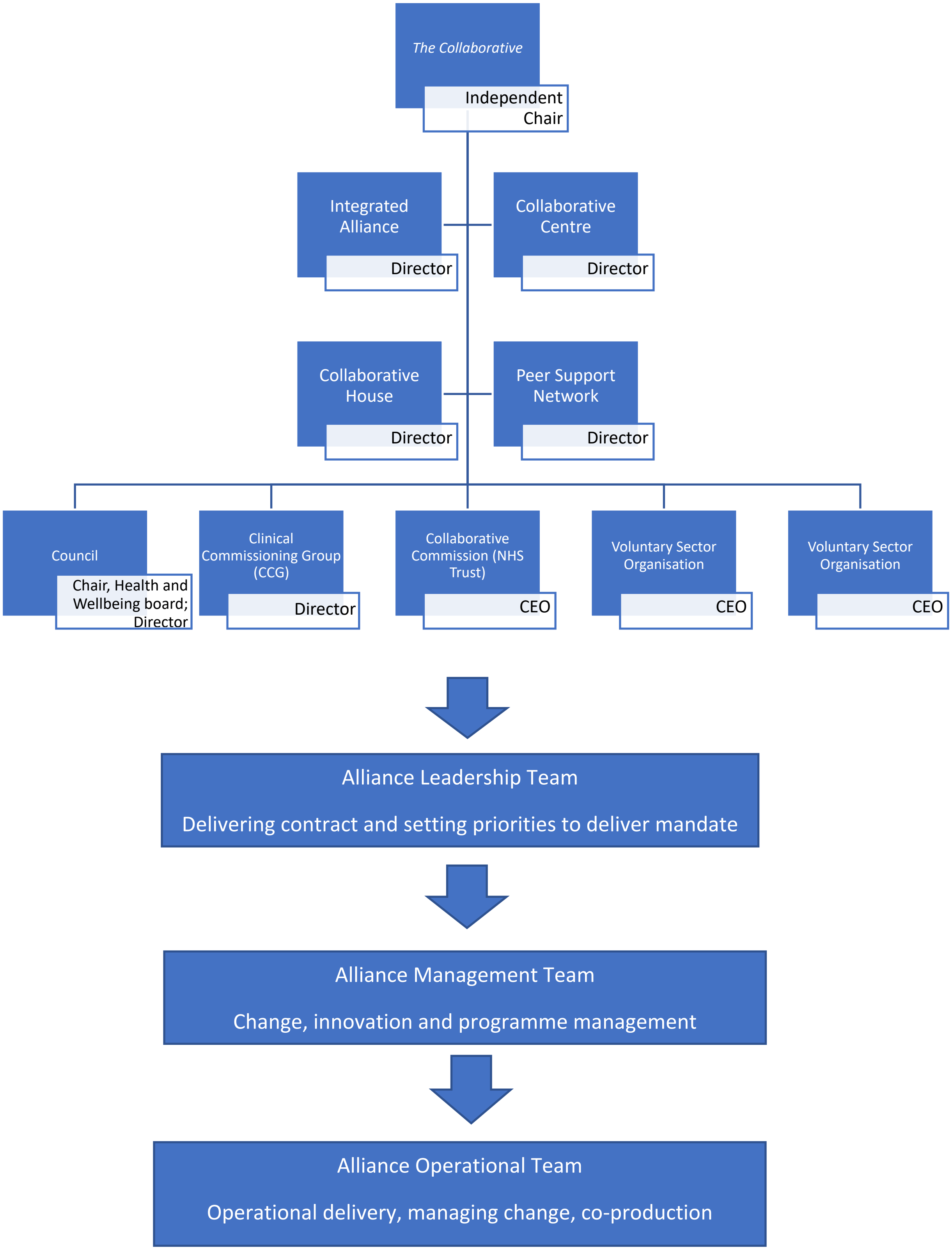


Source: Together Transition Programme (2017)

In November 2013, a Provider Alliance Group (PAG) was established to co-ordinate a response. It consisted of leaders from the collaborative organisations such as charities, Collaborative Commission, Council and the GP Service. The PAG was replaced by Alliance Leadership team and Alliance Management team. The Alliance Operational team has responsibilities of operational delivery, managing change and co-production and formed in the organogram (Figure 1.2). Two larger scale projects have also been implemented: Collaborative Network and Integration Alliance. The Collaborative Network was formed to provide earlier support to people with common mental health needs. It functions as a 'front door' to mental health services. The support it provides is holistic, asset-based, building on people's strengths, skills, interests and connections within communities. The Council and CCG were keen to test out a more formal approach to build on the good progress being made with informal collaborations. The establishment of the Integration Alliance in April 2015, which aims to support people with serious mental illness in leading more independent lives in the community, was another important milestone. The main focus of Integration Alliance is around 200 people in complex care placements, and that test it out for real and new alliance. The Collaborative Hub (CH) opened in June 2015, which was the common front door for people with mental health experiencing mental health difficulties. The current structure of *The Collaborative* (Figure 1.2) is the partnership of the five partner organisations, the Council, Collaborative Commission, which is an NHS Trust, Clinical Commissioning Group and two voluntary sector organisations, having signed the alliance contract, for all working age adults' mental health services. The four main services of *The Collaborative* include Integrated Alliance, Collaborative House, Collaborative Centre and Peer

Support Network and the leaders of these services belong to the Alliance Leadership team and the Alliance Management team.

Figure 1.2 ***The Collaborative*** **Organisational Structure**



This was a common space to commence a mission to overhaul the borough's whole mental health treatment system for the benefit of individuals who required mental health services, and to ask the question: *How has The Collaborative facilitated the integrated care process for mental health outcomes in one London Borough*?

1.4 Aims and Objectives of the Research

The Collaborative, where local stakeholder groups, such as service users, caregivers, voluntary sector providers, primary care, social care, commissioners, and secondary care work together, was first established in 2010 to bring changes in the mental health system in a local authority.

The overall aim of this qualitative case study is to explore and examine the integrated working within *The Collaborative*. The study will lead to greater public understanding and possible policy development on the health and wellbeing of the people in research and in other boroughs. It has explored the leadership team, professional and staff views on *The Collaborative*, how its processes were implemented to integrated working for mental health outcomes and how it has impacted on people who experienced mental health difficulties. Furthermore, it has investigated what impact the coalition has had on service users.

Objectives

1. To analyse relevant policy documents to identify the priorities that have played a role in implementing and supporting *The Collaborative*.

2. To critically consider the impact and implications of policy development (2010 – 2018) leading to the establishment of *The Collaborative*.

3. To explore the views and experiences of the leadership team and professionals working within *The Collaborative* on the process of implementing the initiative and its impact on the mental health of the population.

4. To explore the views and experiences of the staff working within *The Collaborative* on the process of implementing the initiative and its impact on the mental health of the population.

5. To identify the possible effects of *The Collaborative* on the service users on their mental health condition, based on the views of the leadership team, professionals and staff.

6. To provide policy and practice improvement recommendations for integrated mental health provisions based on the application of findings from the study.

1.5 Research Question

This case study investigated how one London borough has managed to facilitate the process of integrated care for its population's mental health outcomes and asks the research question: '*How has The Collaborative facilitated the integrated care process for mental health outcomes in one London Borough*?'

1.6 Personal Motivation

I have always had a passion for supporting and developing my local community. Between 2014 and 2015, I served as Mayor of a London borough and later chaired the Health and Wellbeing Board in the same borough, although not in the research borough. As Mayor, I collaborated extensively with two health and wellness organisations, eventually establishing my own charity toward the conclusion of my service. My charity's objective is to eliminate stigma associated with mental illness and to raise awareness, particularly among underserved communities. My position as Chair of the Health and Wellbeing Board has always been centred on the integration agenda. However, while in post, I discovered a dearth of facts and information around what constitutes successful integration and integrated care in mental health provision. There was a lot of enthusiasm and push for integrated care in my area of work. Despite the abundance of policy instructions, I was unable to locate any evaluations of the integration process's impact or efficacy.

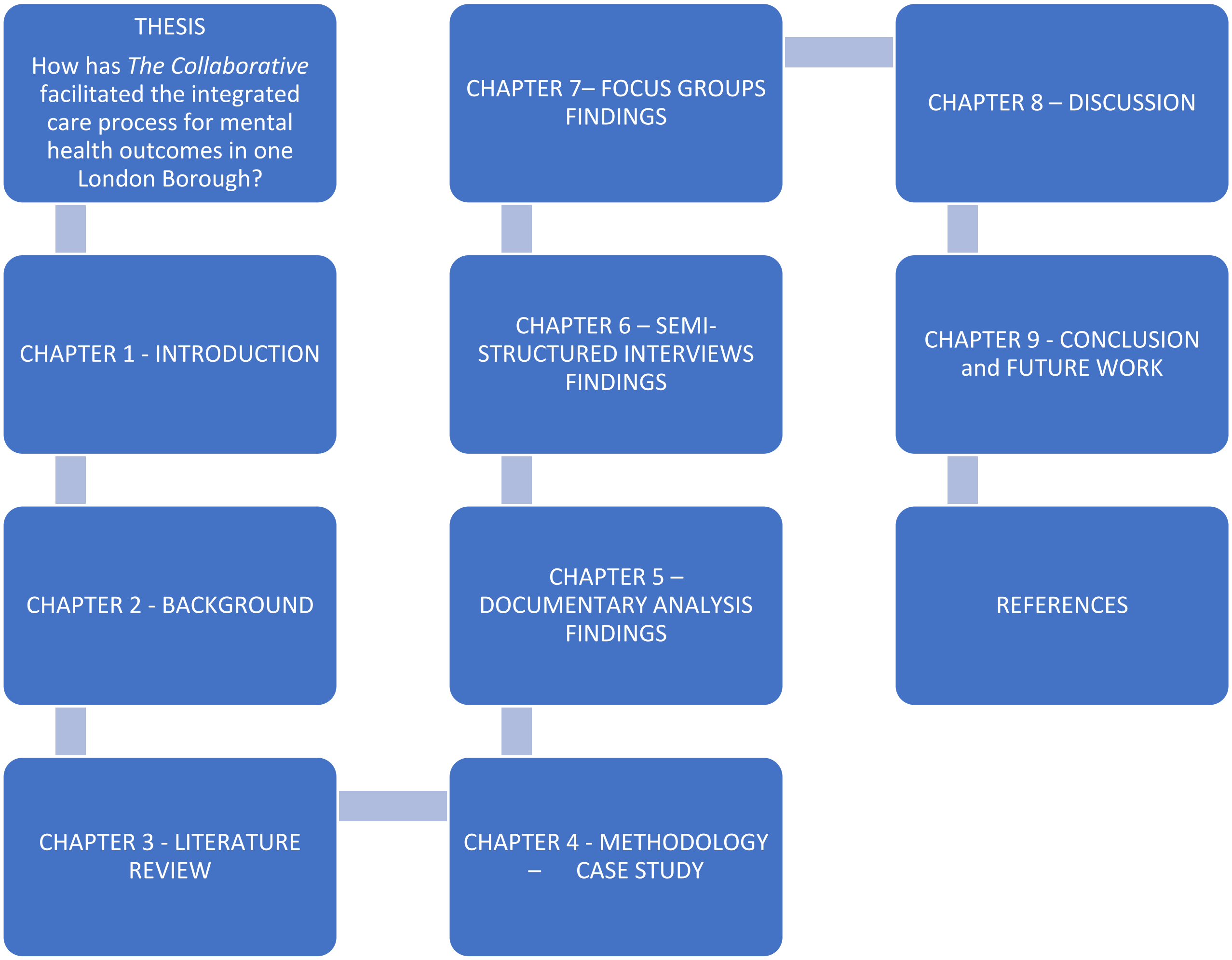
As a councillor for a London borough, I observed that mental illness is the leading cause of disease burden, surpassing cancer and cardiovascular disease, and the associated expenses extend well beyond health and social care. Around 1 in every 4 individuals may encounter a diagnosable mental health illness during any given year. One-third of these individuals will experience two or more conditions concurrently. Mental illness has a profound effect on all part of people's life and it impairs educational progress and has a negative influence on business and industry through sickness absence and worklessness. As Chair of the Health and Wellbeing Board, I am aware of the challenges service users have in accessing mental health services and the dearth of aftercare support. Obtaining assistance can appear to be a massive undertaking at first, and it's all too easy for individuals to become discouraged if the outcome falls short of their expectations. Additionally, a lack of aftercare support has increased the chance of service users' mental illness worsening, resulting in a higher rate of readmission to the hospital. Mental health varies considerably by location but is frequently formed by deprivation and socioeconomic background, as I have witnessed in the borough where I serve as a councillor. Mental health service users were disregarded among primary, secondary, social, and third sector settings. It is recognised that providing high-quality care requires dismantling the conventional division between primary care, community services, social care, mental health care, and hospitals, as well as accepting full responsibilities for population health outcomes.

As a strong proponent of personal development through education and a seeker of knowledge about the nature of integrated care in my local communities, I decided to pursue a PhD. To me, the PhD has been a process of education that has improved my ability to grasp, critique, and conduct research. However, and perhaps most importantly, the PhD has enabled me to become a more effective and educated advocate for the individuals I serve.

1.7 Structure of the Thesis

As can be seen in Figure 1.3, Chapter Two details the background to the integration of health and social care and mental health. Chapter Three considers the literature on important concepts central to integrated care that were found to be specifically effective for individuals with mental health needs, and also concepts that arose as this research study developed. The chapter has established that there is a gap in the research exploring the integration of health and social care in mental health provision in the UK, and around the world. For far too long, mental illnesses have been mostly ignored when it comes to improving primary care. This is despite the fact that mental illnesses affect people from all walks of life, in both rural and urban environments, in both men and women, at all phases of life, and in all socio-economic groups. Therefore, this chapter has attempted to critically analyse and explore the integration initiatives on adult mental health globally.

Figure 1.3 Overall Structure of Thesis



The aims of this research study and the study methods that were selected for use are discussed in Chapter Four. More specifically, this chapter considers the rationale for the selection of aims, the study setting in which this research was conducted and the ethical approaches that were used to protect research participants. This is followed by a discussion regarding the philosophical and practical implications of using an evaluation approach with a qualitative method research design. Finally, this chapter considers the specific methods that were used, provides details of validity and reliability testing, the sampling frameworks used for each phase of the study, and the approaches used in the analysis of the data.

The study findings are presented in three chapters. Chapter Five presents the results of the documentary analysis, which is a research method related to the analysis of documents that contain information about the integration of health and social care and mental health. In this research, seven collaborative documents were analysed using some of the close reading and exploration techniques suggested by Braun and Clarke's (2006) method of thematic analysis, and also drawing on Carabine’s approach to exploring interactions across the policies (Carabine, 2001). The findings illustrate the relationship between the identified themes.

Chapter Six considers the results of 13 semi-structured interviews conducted with the directors of the Alliance Leadership team and Alliance Management team, including the Council, NHS, CCG and local charities. The data were analysed thematically to explore specific aspects of working in *The Collaborative* and achieving integration of health and social care that included accessing resources, teamwork, time issues, staffing issues, integrated working, and improving the mental health of the population. This chapter also provides details of the demographic characteristics of the population who participated in this study, and it includes partners of *The Collaborative*.

Chapter Seven looks specifically at the experiences of the operational staff at the partners of *The Collaborative* by conducting focus groups with four services which were the integrated alliance, collaborative centre, collaborative house and peer support network. The objective of talking with the focus groups was to assist the researcher in obtaining both collective viewpoints as well as underlying beliefs and attitudes. The focus group discussions also allowed the researcher to gather information from sources other than the participants' own recollections, with the other members frequently functioning as triggers. Similar to the semi-structured interviews, the data were analysed thematically to explore specific aspects of working in *The Collaborative* and achieving improvement for mental health patients.

Chapter Eight provides a discussion on the documentary analysis concerning the experiences of the directors, leadership team and the operational staff from *The Collaborative* in relation to facilitating improved outcomes in the mental health of the population following the move to integrated working. This discussion was conducted in the context of the research findings and existing literature on this subject.

Chapter Nine is the concluding chapter, sharing the original contributions to knowledge, strengths and limitations, insider and outsider perspectives and the recommendations for policy, practice, education and future research.

CHAPTER 2: BACKGROUND

2.1 Introduction

This chapter examines the integration of health and social care in England. It establishes the tone for the rest of the thesis by illustrating the present state of integration between health and social care, as well as the history of the topic. Theoretical considerations of integrated care, definitions of integration, potential levels of integration, and the historical separation of health and social care in England will be covered in this chapter. To establish the scene for the proposed study, this section provides an overview of the integration of health and social care and mental health services. The evolution of integrated mental health care since 1601, both before and after the foundation of the NHS, is studied here. The policy context in the United Kingdom is presented to help understand why and how integrated care has evolved. A historical reason for the proposed study is explored, as well as the fact that there is still a paucity of in-depth research into the experiences of leadership teams, operational level employees, and service users.

2.2 What does 'Integration' Mean?

Service users' needs are at the centre of integrated care, which means different things to different people.

'The patient's perspective is at the heart of any discussion about integrated care. Achieving integrated care requires those involved with planning and providing services to impose the patient's perspective as the organising principle of service delivery' (Lloyd and Wait, 2005: p7).

Integration is, by definition, patient- and population-centred. Integrated care is facilitated through the collaboration of processes, practices, and tools. When the conclusion of these procedures directly benefits patients, service users, or communities, it is called integrated care. Successful integrated care can result in better patient experiences, improved treatment outcomes, and more cost-effective delivery, as explained below:

'Without integration at various levels of health systems, all aspects of health care performance can suffer. Patients get lost, needed services fail to be delivered, or are delayed, quality and patient satisfaction decline, and the potential for cost-effectiveness diminishes.' (Kodner and Spreeuwenberg, 2002: p2)

'Integrated care is an organising principle for care delivery that aims to improve patient care and experience through improved coordination. Integration is the combined set of methods, processes and models that seek to bring this about.' (Shaw, Rosen and Rumbold, 2011: p3)

Integration is a concept that is widely used to describe a wide range of health and social care delivery models, and it can be interpreted in different ways by different people (Graham, 2013). For example, Roland et al. (2013) state that '*no single definition of integrated care*' exists (p. 1), whereas in a research report produced by the Nuffield Trust (Shaw, Rosen and Rumbold, 2011), 'integrated care' is an umbrella term, encompassing diverse initiatives that seek to address fragmentation, but that differ in underlying scope and values (Stein and Rieder, 2009). Integration, conversely, is defined in the National Collaboration for Integrated Care and Support (2013) as person-centred, coordinated, and tailored to the needs and preferences of the individual, their carer and family.

'Integration is a process that involves creating and maintaining, over time, a common structure between independent stakeholders ... for the purpose of coordinating their interdependence in order to enable them to work together on a collective project', according to Kodner and Spreeuwenberg (2002). Internal (inside the NHS) and external (NHS with social services) integration is also distinguished by Shaw, Rosen and Rumbold (2011). '*Integration can take a multitude of forms - ranging from a casual partnership between different providers to comprehensive mergers,'* Shaw and Levenson (2011) write (p. 4). As a result, the term 'integration' has been used in the literature to refer to a variety of arrangements, including partnership working, collaborative working, and integrated working, to mention a few (Dickson et al., 2009; Glasby and Dickinson, 2014; Department of Health, 2013). Within the relevant literature (Roland et al., 2013), there is no single definition of integration and integrated care, which may cause uncertainty for service users, professionals working in the sector, and policymakers (Barr, 2002; Cancer Campaigning Group, 2012). A lack of definition has been mentioned as a source of misunderstanding for service users; the Cancer Campaigning Group (2012) recommends a working definition of integrated care for service users after consulting them.

National Voices (2012), on the other hand, claim that a definition is not necessary: '*...people want coordination, not necessarily (organisational) integration. People want care. Where it comes from is secondary…They expect professionals to work together as a team around the patient, and they want services to work together likewise: that is, to come together at the point they are needed, and to meet people's needs in the round.'* (p. 1).

Although the many formulations of integrated care provision may perplex service users, it appears that the most important factor is the care received, not how it is coordinated or articulated. For this study, integrated care is a concept that refers to a desire to improve the service users' experience while also increasing the efficiency and value of health and care delivery systems. It attempts to address fragmentation in patient services and enable better coordinated and continuous care (Shaw, Rosen and Rumbold, 2011).

From the research findings, the Integrated Care definition is derived in this thesis as:

"Integrated care is partnerships that bring together providers, commissioners and settings of NHS services, local authorities and voluntary and community sector organisations, by joining up hospital and community-based services, to collectively plan health and care services to meet the needs of the population and improve the service users' experience."

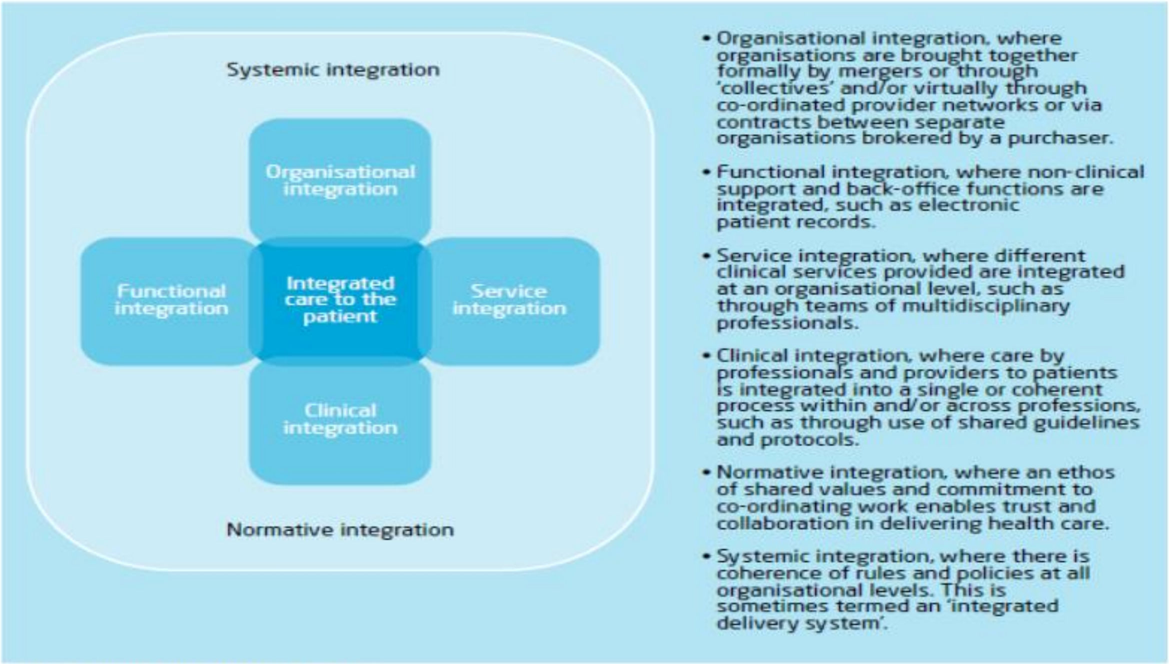
2.3 Types of Integration

Shortell et al. (1993) and Shortell, Gillies and Anderson (1994) have defined organised delivery systems (ODSs) as networks of organisations that provide or arrange to provide a coordinated continuum of services to a defined population and are willing to be held clinically and financially accountable for the population's outcomes and health status. Primary, secondary, tertiary, restorative/rehabilitative, and long-term care are all covered by ODSs. The breadth, depth, and geographic dispersion of an ODS are its most important properties. ODSs do not require common ownership; instead, clinical and financial accountability to a defined population binds the organisation together.

Since Shortell et al.'s (1993) ground-breaking work, integrated healthcare definitions and models have focused on the coordination of health services across the continuum of care, as well as collaboration among clinicians and provider organisations in the delivery of health services. Two methods of integration have been identified: horizontal integration, which occurs when activities across operating units and/or organisations that are at the same stage in the process of delivering services come together, and vertical integration, which refers to the coordination of services amongst operating units that are at various stages of the service delivery process. By merging primary and secondary care, or general practice and community care, for example, vertical integration integrates organisations at different levels of the hierarchical structure under one management umbrella (Humphries and Curry, 2011).

The study by Fulop et al. (2005) reveals that the types of integration focus on governance and organisational structure and, thus, only look at the structural changes that result from the merging of services, rather than the ways that these changes influence processes and cultures, which are similar to change management concepts (Kotter, 1997; Hayes, 2007). Fulop et al. suggest, based on evidence from a variety of studies, that integration happens along five dimensions: organisational, functional, service level, clinical level, and can be normative or systemic, as illustrated in Figure 2.1.

Figure 2.1 Fulop's Typologies of Integrated Care (Adapted from Lewis et al., (2009))



- Organisational integration, where organisations are brought together formally by mergers or through 'collectives' and/or virtually through co-ordinated provider networks or via contracts between separate organisations brokered by a purchaser.
- Functional integration, where non-clinical support and back-office functions are integrated, such as electronic patient records.
- Service integration, where different clinical services provided are integrated at an organisational level, such as through teams of multidisciplinary professionals.
- Clinical integration, where care by professionals and providers to patients is integrated into a single or coherent process within and/or across professions, such as through use of shared guidelines and protocols.
- Normative integration, where an ethos of shared values and commitment to co-ordinating work enables trust and collaboration in delivering health care.
- Systemic integration, where there is coherence of rules and policies at all organisational levels. This is sometimes termed an 'integrated delivery system'.

Source: Adapted from Fulop *et al* (2005)

To create networks, acquisitions, contracts, or strategic partnerships amongst healthcare facilities, healthcare organisations can be referred to as organisational integration. Functional integration is the extent to which key support functions and activities such as financial management, human resources, strategic planning, information management and quality improvement are coordinated across the operating unit. Service integration includes cooperative practices by healthcare providers inside and between organisations, contractual agreements, and strategic partnerships. A critical factor in good clinical integration is the amount of coordination and communication across the employees, roles, activities, and operating units of a healthcare system. Cultural integration concerns the convergence of values, norms, working techniques, approaches, and symbols normative integration involves. Systemic integration can be the integration of objectives, interests, power and resources (Nolte and McKee, 2008). The degree to which organisations and services must integrate is determined by the client's requirements. When it comes to people with severe, complicated, and long-term requirements, full (organisational) integration works best (Leutz, 1999).

2.4 History of Integration

2.4.1 Before NHS Establishment: Voluntary and Family Care

In England, health and social care have always been delivered separately. Independent, mostly non-profit or voluntary sector, organisations have played an important role in the provision of health and social care for the elderly and disabled, frequently cooperating with local municipal and poor law authorities. The poor law of 1601 mandated that local governments care for the old and infirm (Thane, 2009). The establishment of workhouses, which were provided by the local authorities in each region for those who were capable of work but otherwise poor, as well as care for the aged and infirm, was a stepping stone toward the current means-tested social care system in England (Thane, 2009). Those seeking admission to the workhouse were expected to provide information at the time of admission that would establish their position within the institution, such as whether they were able to work or only needed care (Higginbotham, 2012). Due to the poor quality of treatment offered to the infirm in workhouses, legislation was introduced in 1885 requiring workhouse inmates to receive health care in a separate but close location.

For a long time, people who needed help with daily activities were placed in almshouses and care institutions, which were run by religious groups and other volunteer and philanthropic organisations. These institutions were funded in large part by donations and fees charged to those who could afford them. Voluntary visiting associations provided care in the community, particularly in the eighteenth century. To increase help for the ‘deserving poor’, voluntary organisations, the poor law and local authorities frequently partnered. Although it is impossible to define the scope of their activity, it was inherently diverse and unable to address all the needs on a local level. Voluntary hospitals, particularly those in London, gave free treatment to those in need.

While charging others, the poor were treated for acute rather than chronic diseases, thus the disparity. The poor who had been sick or incapacitated for a long time were sent to workhouse hospitals. Private mental institutions arose in the 18th and 19th centuries, with most patients paying a fee. Before the Second World War, the volunteer sector was well-established in the provision of care, frequently partnering with government organisations.

The Poor Law Amendment Act was passed in 1834 (Theobald) to reduce the cost of looking after the poor and to encourage poor people to work hard to support themselves. The Act abolished all existing systems for giving poor relief. Under the reform, outdoor relief, the financial support formerly given to the able-bodied, was no longer available to them. In the community, they received minimal benefits in cash, food or clothing. They had to go into a workhouse if they needed the relief. Workhouses were to offer a standard of living lower than anything available outside (Rogers, 1889). This was called less eligibility. Unions could give outdoor relief, especially to the elderly, the sick and young children. Over time, only orphans, the elderly, the sick and the disabled people became the habitants of the workhouses. It should not be a surprise to learn that the new Poor Law was unpopular. It was like punishing those who had no control over their economic status. People caring for the impoverished rarely received assistance under the revised poor legislation. George Nicholls, the overseer at Southwell, the second workhouse built, wrote:

'The workhouse inmate is better off than the ordinary labourer. He is better fed, better clothed, better attended to in sickness, better cared for in health, and far more lightly worked; and were it not for the restraints imposed as the condition of his reception, the workhouse would too probably become an incentive to pauperism, instead of being a check or preventative.' (Hansard, 1962)

As the population of workhouses grew older and more chronically ill, infirmary wings were established, frequently with subpar nursing and medical care (Nicholls, 1853). During the Victorian era in Britain, from 1837 to 1851, religion was far from second to healthcare (Woodhead, 2011). Life was physically unpleasant; medical relief was (by contemporary standards) inaccessible and unsophisticated; religion gave both an explanation for calamity and a store of solace: God was seen as the supreme practitioner and Jesus as the physician of the soul. Medical practitioners frequently felt a moral obligation toward patients, churches accepted a medical obligation toward parishioners, and healing and preaching were intertwined in the gospels. In the nineteenth century, medicine in the hands of Christians, inevitably led to ethics, while ethics in the hands of religious people led to medical philanthropy. The task of missionary medicine was to deliver a double cure: to dedicate medicine to the service of Christ while also providing an everlasting cure. Medicine's inability to heal patients' bodies or provide an explanation for death bolstered faith. Overall, medical treatment was in severe need in nineteenth-century Britain, particularly in the country's poorest districts, where little help was available beyond making the sick and dying more comfortable and praying for their souls. Nurses were frequently forced to take theology classes in Victorian nursing schools. Christianity may have made it more difficult to live, but it made it easier to die, according to many nineteenth-century witnesses to the faith.

Officially, social work began as a movement in the nineteenth century, largely in the United States (US) and the United Kingdom. Following the collapse of feudalism, persons in poverty were considered to be a direct threat to the social order; therefore, the government enacted the Poor Law and established a system to care for them. While the industrial revolution resulted in significant technological and scientific achievements, large-scale migration to urban areas across the Western world resulted in greater social problems and, as a result, increasing social activism. During this time, rescue societies were formed to help people overcome challenges, including poverty, disease, prostitution, mental illness, and other maladies.

In the late 1800s, a new system for giving relief for societal evils evolved. Settlement houses were constructed in disadvantaged metropolitan areas as part of the settlement house movement for volunteer middle-class social workers to help their low-income neighbours. Early social workers in the movement provided educational, legal, and health services to the poor, focusing on the roots of poverty through research, change, and residence. Three strands in the evolution of social work are charted after Seed (1973). The first is the emphasis on individual casework, which stems from the Charity Organisation Society's (COS) work (Woodroofe, 1962; Lewis, 1996). The second is social work's involvement in social administration, which includes (but is not limited to) many forms of poverty relief. While much of this stems from the Poor Law (Monk, 1986), it was also fostered, in part, by the efforts of the COS. The third is the emphasis on social action, which has been linked to the rise of the settlement movement in both the United Kingdom and the United States (Rose, 2001).

The Royal Commission on the Poor Law and the Unemployed was founded in 1905 to examine the law’s system of assisting the unemployed. The majority report, which came out four years later, indicated that there was too much being provided and that workhouses should be replaced with institutions to shelter different populations, such as children, the elderly, and the mentally ill. In contrast, the minority report, led by social reformer Beatrice Webb, advocated for the entire repeal of the Poor Law, instead calling for a focus on addressing the structural roots of poverty. Nevile Chamberlain’s Local Government Act 1929 abolished the English Poor Law guardians and transferred poor relief into public assistance. The health and assistance function of the Poor Law was intended to be divided between the new public health and public assistance committees of the local county or borough councils.

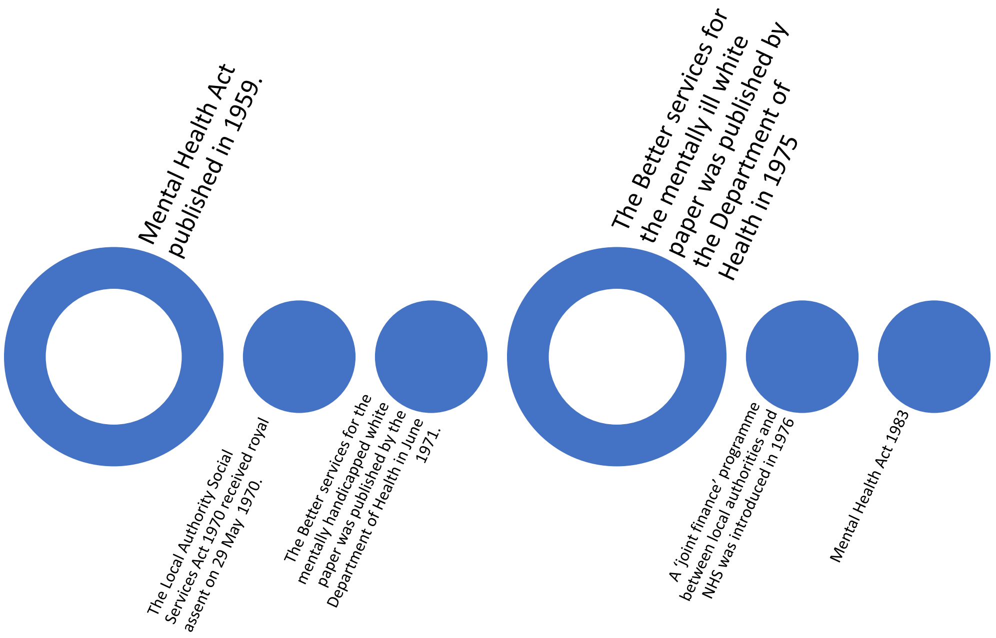
2.4.2 Since NHS Establishment

In 1948, the NHS was born and it was a culmination of a bold and pioneering plan to make healthcare no longer exclusive to those who could afford it but to make it accessible to everyone (Gorsky, 2008). The NHS and personal social services, which are accessible through both a means test and eligibility criteria via the LA, are both descendants of these previous mechanisms for providing treatment and care (Department of Health, 2003). As a result, since the national supply of health and social care started in England, there have been variances in the provision of these services. In England, the separation of health and social care is still visible, both in practice and in policymaking. Working together, inside and across these services, is still the exception rather than the norm (Ham, 2012). While both the NHS and local governments serve the same population, these organisations have different funding sources, ways of procuring services, the procedures they use to make decisions, and the terms and conditions of their workforce, all of which have been acknowledged as obstacles to integrated service delivery (Stirling et al., 2013; Khaldi, 2013; Roland et al., 2013).

The real impetus for the present policies of care in the community began in the late 1950s. As shown in Figure 2.2, the Mental Health Act (1959) aimed to prioritise community care and the belief that patients with mental ill health should not be considered any different from other types of sick people. Since then, a succession of governments has sought to shift the care of people with mental health away from institutions to care in their own homes because of the high costs incurred by the state and the drive towards independence for this group of service users, who had previously been living in residential care (Thane, 2009). Integral to this shift of care provision was the NHS and Community Care Act (1990), which heralded a new era in the way community care was financed and managed. The NHS and Community Care Act (1990) separated the purchasing and providing functions of the local authority so that a more efficient approach to service delivery could be achieved through the creation of an internal market. This development also demonstrated the intention of policymakers to create an environment within which service provision was to be more centrally-driven and policy controlled through a managerialist approach (Rogers and Pilgrim, 2001). Another key feature of the policy emphasised the need for integrated working between health and social care agencies, and the development of joint commissioning approaches between health and local authorities, which required them to function as integrated multidisciplinary teams.

With the introduction of the Local Authority Social Services Act (1970), a social services department was founded in every local authority to establish a framework for social services and coordinate services across the authority. By putting this strategy in place, families who needed support could be identified and encouraged to get aid (Health Committee, 2009). Domestic assistance, residential accommodation, meals and leisure services (all of which might be charged for), the registration of independent residential houses, and social work assistance were all given to the departments. In the 1970s, a large number of policies was enacted to help the elderly and people with disabilities to stay in the community, driven, in part, by disabled people's advocacy.

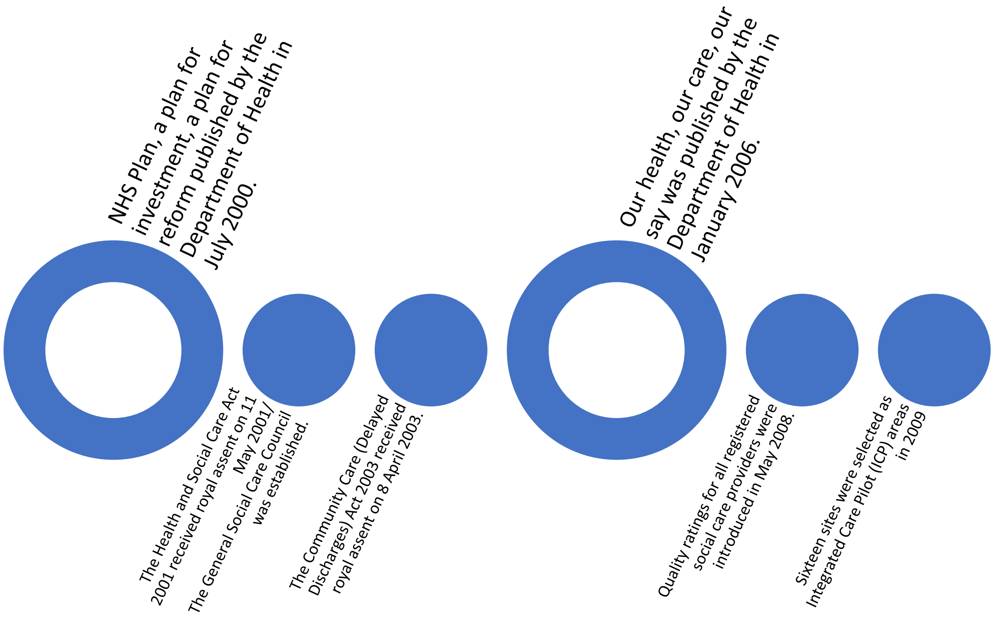
Figure 2.2 Timeline of Integrated Care since NHS Establishment



2.4.3 During 1997 – 2010

The convergence of government health and social policies was again brought to the forefront with the victory of New Labour in 1997. New Labour's White Paper 'The New NHS', in 1997, proposed that services should be constructed around the requirements of patients, who could be certain of timely and reliable responses. This white paper dismantled the internal markets of the earlier 'Working for Patients' white paper, and more money was made available for the NHS (Rivett, 2017). Coordinated, cross-collaboration would minimise the length of hospital stay, improve hospital discharges and broaden community-based activities (Dickson et al., 2009).

Figure 2.3 Timeline Integrated Care during 1997 – 2010



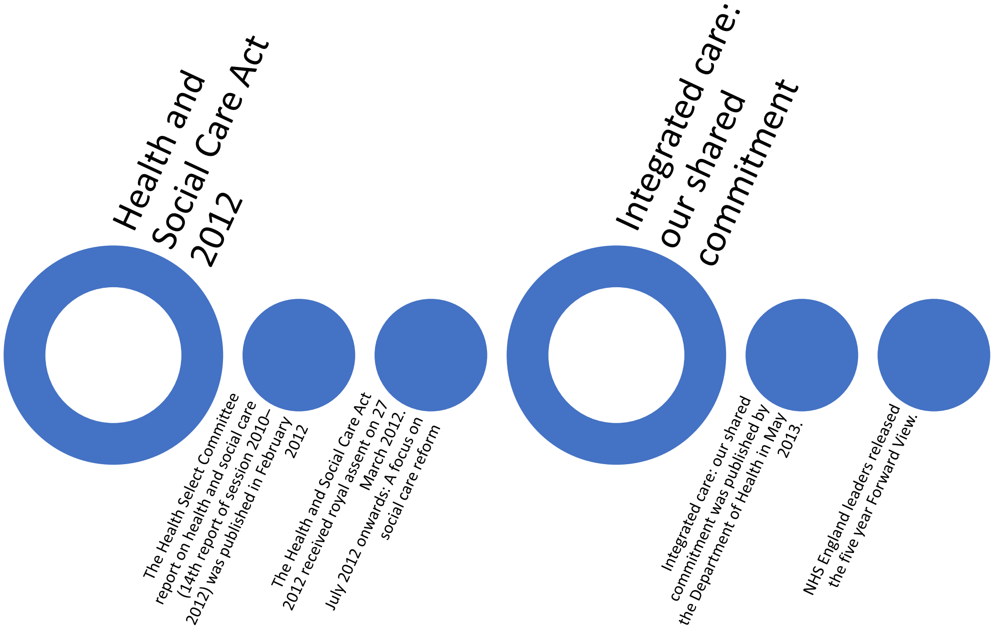
The white paper ‘Our Health, Our Care, Our Say’ (Figure 2.3), issued by the Labour administration in January 2006, outlined a new path for the health and social care system by providing more community care services, as well as greater choice and a greater voice for service users. In June 2008, the report ‘High-Quality Care for All’ emphasised the need for the NHS to collaborate with other authorities and organisations to increase the prevention of illness. It added that these initiatives should go through a rigorous procedure to identify which would work best, engaging patients, caregivers, the general public, and staff, and all while communicating properly. It also outlined plans to establish new integrated care organisations (ICOs) which would bring together health and social care experts to provide more personalised, responsive, and coordinated care. Following this, the ICOs emerged as a series of Department of Health-sponsored pilots, 16 of which were launched in April 2009 and operational for two years.

Since the election of the new Labour government in 1997, joined up, multidisciplinary collaboration has been a fundamental aspect of delivering services to people with mental health issues in the UK, at both a local and national level. Policies, such as the NHS Plan (Department of Health, 2000a), have placed a great deal of emphasis on integrated working with people with mental health issues, as they are a group whose complex needs often require help from more than one agency. This means that with the move from hospital to the community, integration of care and coordination of services have become even more essential (Corney, 1995). For similar reasons, people with mental health issues could also require the intervention of several professionals at any given time.

2.4.4 Post-2010

In 2010, primary, community, mental health, acute, and certain specialised services were commissioned by 152 primary care trusts (PCTs). Following the 2010 general election, the coalition government embarked on a reform programme, the centrepiece of which was the Health and Social Care Act (2012a) (Figure 2.4), which made significant changes to the way the NHS in England was organised. The main focus of the reforms was to increase clinical leadership in commissioning: the coalition agreement set out the government's intention to ‘strengthen clinical leadership in commissioning’ (House of Commons, 2012). The integration of care was not a stated goal of the initial reforms, but it became a key component after the NHS Future Forum's work in 2011. The bill was revised to include obligations for numerous organisations to support integrated care, which were strengthened by the Care Act (2014) (Ham and Murray, 2015).

Figure 2.4 Timeline Integrated Care Post-2010



Health and wellbeing boards were established to offer a platform for cooperation between local organisations, and new and existing organisations were assigned varied responsibilities to support integrated care. Local governments were also required by the Care Act (2014) to foster integrated functioning. Representatives from LAs, CCGs, and local Healthwatch organisations, as well as additional members nominated at the discretion of local regions, were presented as a key aspect of the government's strategy for allowing whole-system collaboration (Cameron, 2016). Some CCGs experimented with different commissions and contracting models, primarily as a means of promoting more integrated care. Alliance contracts, for example, were evaluated in a variety of sectors, including the research borough (Shortell et al., 2015). The Care Bill (2013), one of the most recent changes, is possibly the most important for the study presented in this thesis (Department of Health, 2013). According to this bill, a local authority must guarantee the integration of care and support services if the particular local authority finds any advantage for the specific population within the region.

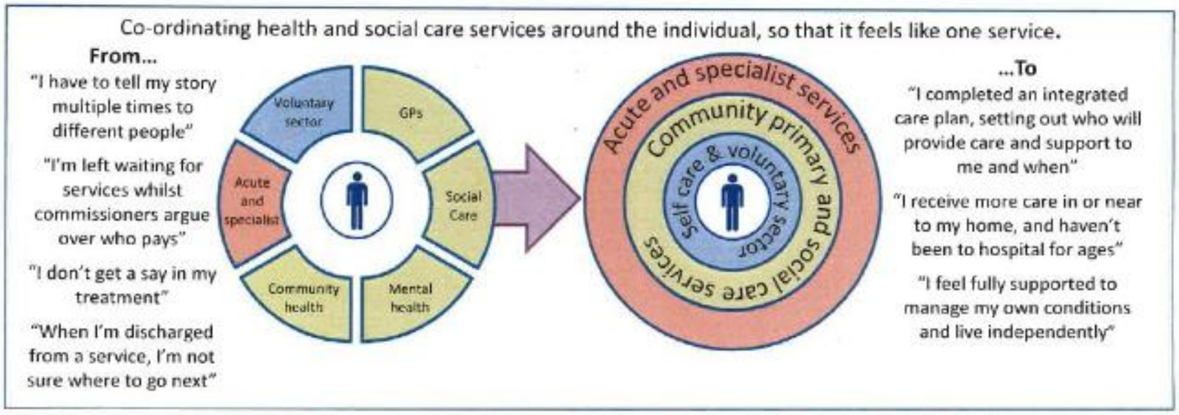
In the UK, the creation of community mental health teams (CMHTs) was seen as a key development in the delivery of a modern de-institutionalised mental health service where the care of service users shifted away from institutions and into the community. The mental health policy implementation guide for CMHTs (Department of Health, 2002) stated that: '*in order to achieve this transition the role of community mental health teams involves the use of an integrated, multidisciplinary approach with each team having an adequate skill mix in order to provide for all interventions, notably the skills of nursing, social work, psychology and medicine*'. It also stated that: '*ideally teams should consist of integrated health and social care staff using one set of notes and clear overall clinical and managerial leadership, with all team members located in the same office. Thus, integrated care will be provided by the team as opposed to any one individual within it*'. However, following the creation of CMHTs, some concerns were raised in relation to the historical conflict between health and social services in terms of their different structures and the value base of the various professional groups within the teams. It is important, therefore, to understand the implications that these organisational changes have had for professionals' experiences of integrated working in terms of achieving improvement in the mental health of the population.

In addition, the policy which introduced integrated working has required local change agents to implement a significant number of major changes within organisations. These changes, based on a multifaceted approach, have affected several aspects of working that include the funding, goals, structures, cultures, and the role of management within public sector organisations such as the NHS

(Doyle, Claydon and Buchanan, 2008). Thus, principles of service provision taken from a managerialist perspective imply that decentralised structures with accountable managers who operate on market principles, using private sector techniques that emphasise efficiency and effectiveness, provide value for money and quality of service (Doyle, Claydon and Buchanan, 2008). In this study, these complexities of implementing change in the NHS are considered in terms of models of change, e. g., the content, context and process model developed by Pettigrew, Ferlie and McKee (1992), to help understand the relevant aspects of the change process that have taken place.

The arena of mental health, following the integration of health and social care, has long been beset by competing discourses that highlight the different ways of conceptualising and responding to the situations that are posed when working with people with mental health issues (Fawcett, 2005). Approaches that relate to the health of the person and define problems as illnesses, and which are treated predominantly, but not exclusively, with drug and physical treatments (Rees, 1976; Howe, 1995), have been set against more socially orientated models which focus on removing stigma, the stressing of citizenship rights and the promotion of a broader-based response to mental distress (Rogers and Pilgrim, 2010; Fawcett, 2005). In multidisciplinary teams, the role played by the operational staff has been one where they have been able to call upon their knowledge of the communities in which carers and users live to bring a social context into team discussions (Rushton, Beaumont and Mayes, 2000). A growing body of implementation sciences literature (Tansella and Thornicroft, 2009) has indicated that negative attitudes to work are a major block to the successful dissemination of innovations intended to improve patient experiences and outcomes, and the multi-discipline teams that provide the patient services, treatment and care. Thus, study objectives 3 and 4 of this research explore *The Collaborative*'s multi-discipline team's experience of aspects of integrated working and how this has influenced integrated care for people with mental illness. (WHO World Mental Health Survey Consortium, 2020). The 2015 Spending Review set out an ambitious plan so that by 2020, health and social care would be integrated across the country (Figure 2.5). Every part of the country had to have a plan for this in 2017, to be implemented by 2020.

Figure 2.5 Integration of Health and Social Care, in Every Area of England, by 2020



Co-ordinating health and social care services around the individual, so that it feels like one service.

From...

"I have to tell my story multiple times to different people"

"I'm left waiting for services whilst commissioners argue over who pays"

"I don't get a say in my treatment"

"When I'm discharged from a service, I'm not sure where to go next"

...To

"I completed an integrated care plan, setting out who will provide care and support to me and when"

"I receive more care in or near to my home, and haven't been to hospital for ages"

"I feel fully supported to manage my own conditions and live independently"

Source: The Social Care Institute for Excellence Scoping Research 2017

While there are examples across England of health and social care sectors being successfully integrated, it would be a long time before it was implemented everywhere (Social Care Institute for Excellence, 2017). Governments had to do their utmost to tear down hurdles to integration across the country. There had to be more collaboration across departments and organisations so that best practices could be disseminated, along with governance essential to implement innovation at the community level. In addition, minimal information and examples of integrated care from around the UK was available, particularly related to mental health. An intended outcome of this research is to explore an integrated health and social care initiative of mental health services and examine the applicability and the visibility of the integrated agenda in one London borough. While the findings acknowledge that *The Collaborative* is still a long way from where they want to be, this research will add to the growing body of literature related to policy development in integrated care and mental health to ultimately benefit other areas in the UK.

CHAPTER 3: LITERATURE REVIEW

3.1 Introduction

This chapter presents a comprehensive assessment of the worldwide literature relevant to integrated care that has been found to be particularly helpful for people with mental health problems, as well as concepts that have emerged as the research study has progressed. First, the search technique utilised and the selection criteria used to include/exclude publications will be described in depth. The chapter has established a gap in the research exploring the integration of health and social care in mental health provision in the United Kingdom and around the world. For far too long, mental disorders have been mostly ignored when it comes to improving primary care. This is even though mental disorders affect people from all walks of life, in both rural and urban environments, in both men and women, at all phases of life, and in all socio-economic groups (World Health Organisation and World Organisation of National Colleges Academies and Academic Associations of General Practitioners/Family Physicians, 2008). As a result, this chapter aims to critically analyse and explore global integration initiatives in adult mental health.

Over the last ten years, health policymakers and researchers have paid greater attention to global mental health. The context for this transformation is defined by data on the prevalence (Demyttenaere et al., 2004) and burden (López et al., 2006) of mental diseases, as well as the resources allocated to mental health within countries (World Health Organisation, 2001, 2005, 2014). The publishing of a series of review papers on various elements of global mental health (The Lancet, 2007, 2011) and Grand Challenges in Global Mental Health (Collins et al., 2011) have highlighted the existing data and knowledge gaps. The Commonwealth, the Asia-Pacific Economic Commission, and the World Health Assembly, which is made up of 194 health ministers, have all discussed mental health at the ministerial level. The WHO's Comprehensive Mental Health Action Plan 2013–2020 (World Health Organisation, 2013) was adopted as a consequence of the latter debate for the first time in the organisation's history.

In England, developing integrated approaches to mental health is a prime objective. People do not always receive coordinated assistance for their physical health, mental health, and wider social needs because mental health treatment is often separated from the wider health and care system. However, a thorough examination of the literature on integrated mental health treatment indicates several gaps and deficiencies in adult treatment. The current review examines perceived hurdles facing and facilitators of integrated working, as well as their implications for promoting community mental health. Finally, this review considers the literature on multidisciplinary team experiences, mental health integration into primary care, and the impact of social and economic variables on integrated working practices.

3.1.1 Aims

The following were the aims of a robust systematic review of the literature published in peer-reviewed journals since 2010:

1. Identifying critical elements of integrated care for people with mental health problems.

2. Evaluating the efficacy of these elements.

3. Conducting a critical interpretive synthesis of the research to determine the areas of health and social care integration that are crucial to service users' recovery.

3.1.2 Methodology

3.1.2.1 Design

The best strategy for analysing existing published studies was to perform a robust systematic literature review (Booth, Sutton and Papaioannou, 2014), which my research questions required. This form of review takes a systematic approach to data collecting (i.e., searching for and identifying literature that addresses the research question), as well as data synthesis and analysis. It improves the review's validity and its possibilities of replication—an important part of research validity (Silverman, 2016). Systematic literature reviews are inherently difficult, but they review the current literature while also identifying a research topic that requires more investigation (Machi and McEvoy, 2016), which is one of the goals of this study.

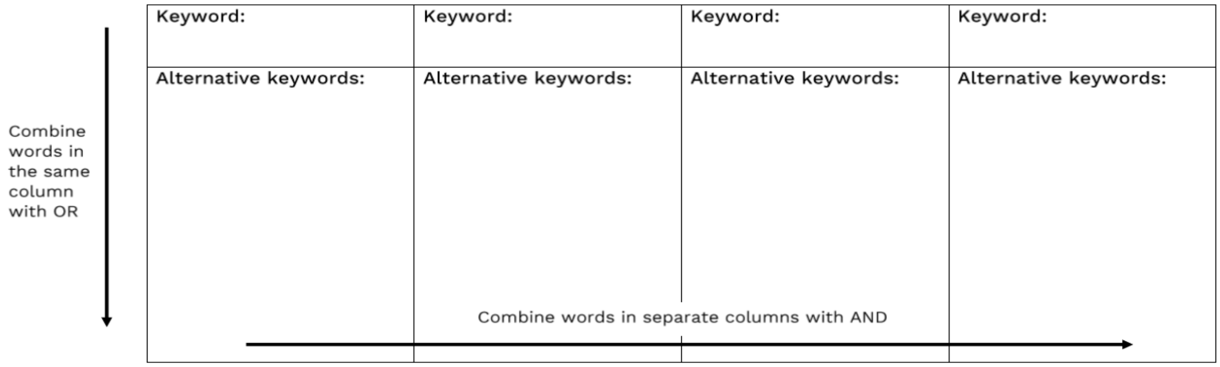
3.1.2.2 Search Strategy and Selection Criteria

Throughout this thesis, relevant literature has been reviewed. Collaboration with librarians and the use of online databases and e-journals, particularly at the University of Greenwich, were used to actively search for published studies. Databases accessed included EBSCO, Academic Search Premier, Business Source Premier, CINAHL Plus with Full Text, Education Research Complete, GreenFILE, Humanities International Complete, LISTA (Library, Information Science and Technology Abstracts), Medline, PsycARTICLES, Psychology and Behavioural Sciences Collection, PsycINFO, Regional Business News, SportDISCUS, Science Direct, Scopus, Cochrane Library and Teacher Reference Centre. The King's Fund, Royal College of Nursing, Social Care Institute for Excellence, Web of Science, and Nuffield were used to search for more particular web-based resources relating to integrated care in adult mental health.

Science Direct provided access to a wide range of literature from a variety of sources, including books and journals. Articles from the International Journal of Integrated Care, the British Medical Journal, Mental Health Weekly - Wiley Online Library, and The Lancet were among the electronic journals accessed using these databases. At the end of several especially relevant journal publications and research reports, hand searches for references were conducted. Government websites were accessed to find evidence-based research reports and policy documents, such as those from the Department of Health and well-known international organisations, like the World Health Organization (WHO). The search was then expanded to include historical and cultural settings of integrated mental health care in the United Kingdom to acquire a better understanding of broad policy perspectives of integrated care.

The approach employed was the Boolean searching approach, which is a logical combinatorial system technique for retrieving information (Merriam-Webster, 2013). The key search words utilised, as well as their combinations, reflected various terminology in connection to the service user, carer, and administration of adult mental health within international integrated health care. Following a review of the current literature (Scott, 2007; Stone et al., 2007; Waldrop and McGuinness, 2017), search terms were generated using the search planning template (Table 3.1) with keywords on the first row by combining keywords in separate columns with AND combining words in the same column with OR (Table 3.2 and 3.3). The initial focus of the literature search was on integrated care, health and social care, and mental health, but it was later refined to include interdisciplinary, co-production, person-centred health and social care, and a whole-system approach to population health and wellbeing.

Table 3.1 Search Planning template



Combine words in the same column with OR

Keyword:	Keyword:	Keyword:	Keyword:
Alternative keywords:	Alternative keywords:	Alternative keywords:	Alternative keywords:

Combine words in separate columns with AND

Table 3.2 Search Terms Using the Planning Template

Integrated Care	Adult Mental Health	Health	Social Care
Whole-system approach	Severe mental illness	Primary health care	Reduce hospital admissions
Co-production	Enduring mental health problems	Secondary health care	Self-management
Multidisciplinary	Mental health services	Documentary analysis	Commission
Integration	Sanctuaries	Power relations	Reduce inpatient admissions
Horizontal integration	Safe havens		Models of care
Vertical integration	Working-age adults Mental health		Person-centred
Interrelationship	Mental health service delivery		Independence
Duplication	Crisis		Self-care
Intervention	Crisis cafés		
Shared services			

Table 3.3 Additional Search Terms

Community health	Transform	Third sector	Voluntary sector	Citizens
Service users	Inequality	Prevention	Evaluation	

Then, various combinations of these search terms were trialled (Table 3.4) before the author settled on a broad search strategy. Hand searches were conducted on many publisher websites, published reviews, and intervention studies. There were no linguistic limitations.

Table 3.4 Combination of Search Terms

Integrated care AND Adult mental health AND Health AND Social care
Integrated Care AND Severe mental illness OR Enduring mental health problems AND Primary health care AND Reduced hospital admissions
Multidisciplinary OR Integration AND Mental health services AND Reduced inpatient admissions
Horizontal integration OR Vertical integration AND Working-age adults mental health AND Secondary health care AND Models of care
Whole-system approach OR Shared services OR Integration AND Crisis AND Independence
Intervention OR Co-production OR Documentary analysis OR Integrated care AND Mental health services OR Crisis OR Sanctuaries OR Safe havens OR Crisis cafes
Integrated care OR Interrelationship OR Duplication AND Mental health Service Delivery AND Self-management OR Person-centred.
Integrated Care AND Severe mental illness AND Commission OR Self-are OR Power relations
Integration AND Working age adults mental health AND Service users OR Citizens AND Inequality
Integration AND Working age adults mental health AND Community health OR Third sector OR Voluntary sector
Evaluation of integration of health and social care AND Adult mental health
Prevention AND Integration of health and social Care AND Adult mental health

3.1.2.3 Inclusion Criteria

The papers that were included investigated interventions in integrated care for adults with mental health issues who were in psychiatric or social care facilities in the hospital or in the community. The review included both qualitative and quantitative research that provided information about the provision of integrated mental health services of health and social care. The assessment was confined to articles published after 2010 since the financial crisis of 2008 and the election of a coalition government in 2010 reignited policymakers' interest in the relevance of integrated care and how to achieve it. This study also explores *The Collaborative*, a group of local stakeholders (service users, caregivers, voluntary sector providers, primary care, social care, commissioners, and secondary care) who got together in 2010 to bring about changes in the mental health system.

3.1.2.4 Exclusion Criteria

Papers were excluded if the focus, setting or client group could not be extrapolated to the care in facilities for adults with mental health problems. Studies that reported on pharmacological trials, investigated patients' quality of life or happiness in isolation from their environment in institutional care or had a focus that was too wide to be appropriate for the review's aims were eliminated. Despite the fact that medication is an important part of the treatment of people with serious mental illnesses, it was not included in this review because there are numerous guidelines (National Institute for Health and Clinical Excellence, 2011; Lehman et al., 2004) that include recommendations on medications and how to monitor their effects and side effects. There was no further comprehensive analysis of each paper contained inside a robust systematic review where it was included. Editorials, letters, novels, conference abstracts, other non-empirical publications (e.g. conceptual pieces), grey literature, and non-peer-reviewed publications were not included in the study. Original empirical research conducted before 2010 was eliminated since the financial crisis of 2008 and the election of a coalition government in 2010 reignited policymakers' interest in the relevance of integrated care and how to accomplish it. Literature reporting mental health services for only children and adolescents or older persons (65+) was excluded, as was literature that was not available in English.

3.1.2.5 Analysis

Unit analysis was used to assess the papers that were chosen (Hashimov, 2015). The writers were able to use this way of analysis to uncover and evaluate the emergent themes from the current review by meticulously identifying recurrent patterns of knowledge. As a result, a thematic analysis approach

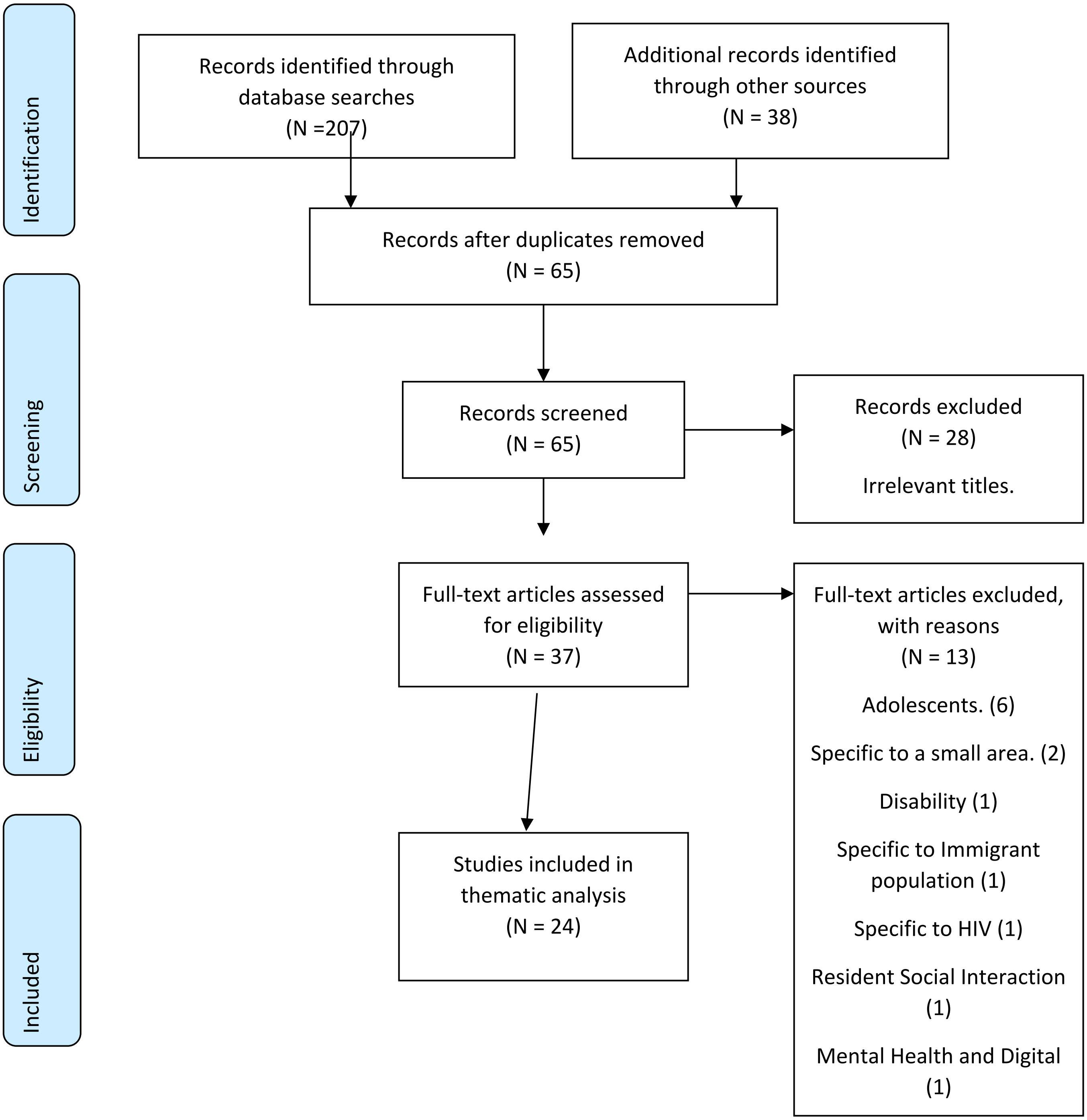
(Hashimov, 2015) was utilised to investigate the review's themes and sub-themes, while the authors adopted an interpretive review approach to investigate the concepts given in the selected articles.

3.1.2.6 Results

A selection method was used to determine the relevancy of the papers found through the database search. Initially, all titles and abstracts were evaluated for relevance, and the full text of all relevant papers was collected. Qualitative papers were included based on their quality, which was determined using the Critical Appraisal Skills Programme (CASP, 2018) framework. This included two screening questions, namely: Was there a clear statement of the research aims? and Is a qualitative methodology appropriate? Both of these required a ‘yes’ before further analysis.

There was a total of 245 papers identified across all databases and additional sources. Before being excluded from or included in the literature review, the abstracts or full texts of the studies were evaluated. For additional analysis and coding, the complete text and international publications of 65 papers from 2010 to 2018 were retrieved. Of these, 41 were excluded, either because the paper was a duplicate or the title and abstract revealed that the paper was not relevant to the aims of the study. For example, the papers excluded did not consider integrated care or adult mental health or they did not meet eligibility criteria; instead, they were about mental health and adolescents, disability, immigrant populations, HIV, or were digital and specific to a small area. Thus, a total of 24 relevant papers met the inclusion criteria after quality assessment as per the PRISMA statement (Moher et al., 2009). Figure 3.1 briefly summarises the key papers that were selected in this process, the methods used and the outcomes of these research studies. The papers included studies undertaken in several countries - 12 in the US, five in the UK, four in Australia, one in Poland, one in Belgium and one in Vietnam. There was a balance of qualitative and quantitative studies.

Figure 3.1 PRISMA Diagram Depicts Different Phases of the Review



The studies reviewed for this research mostly recruited service users with poor mental health, but they also included multidisciplinary provider groups, professionals, and third-party organisations that provide integrated mental health provision. These studies are valuable in understanding the various service models that are used, the interventions that these services provide, as well as the features and demographics of patients who are referred for psychiatric consultation. However, while a few of these studies discussed some outcomes, such as discharge disposition and length of hospital stay, we cannot completely accept the findings for these outcomes because the studies did not account for confounding factors, such as the severity of the physical illness or the availability of social support, both of which have significant effects on primary outcomes.

For example, due to ward reductions and resource transfers to community institutions such as intermediate care teams, the duration of stay of elderly adults in UK hospitals has recently plummeted. The findings of a study of any healthcare intervention carried out during these transitions might lead to the incorrect conclusion that the reduction in length of stay was due to the intervention rather than the service change. The intervention might have had a favourable effect on lowering the duration of stay, but descriptive studies cannot convince us of that without controlling for confounding factors.

Over the past decade, the discussion of integrated care has become more widespread and prominent in both high- and low-income country health care systems. It is worth noting that out of the 24 studies 23 were conducted in high-income countries health care systems, such as the US, UK and Poland and only one of them was based in a low-income country health care system, which was Vietnam. Studies also focused on: integrating primary care into behavioural health speciality settings for people with serious mental illness (SMI) or substance use disorders (SUDs) (Lin et al., 2011) and community-based depression services (Murphy et al., 2017). Following this thorough review of the papers, five themes emerged (Table 3.5); these are discussed in the subsections below.

Table 3.5 The Five Themes and the Corresponding Primary Research Articles

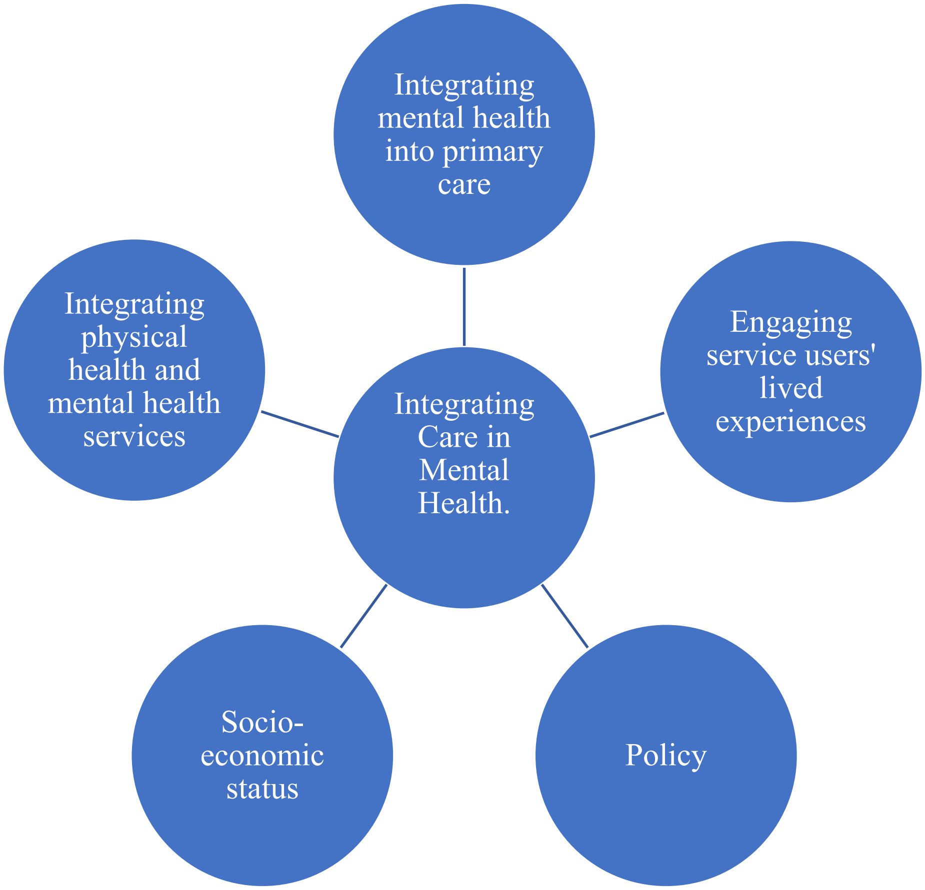
Theme	Integrating mental health into primary care	Integrating physical health and mental health	Engaging service users' lived experiences	Socio-economic status	Policy
Papers	Bauer et al., 2013; Cybulski et al., 2017; Gupta et al., 2018; Lin et al. 2011; Murphy et al., 2017; Padwa et al., 2016; Samuels et al., 2015; Scharf et al., 2016.	Fullerton et al., 2018; Meyer-Kalos et al., 2017; Muralidharan et al., 2019; White et al., 2011; Wright-Berryman and Kim, 2016.	Gaglioti et al., 2017; Jespersen et al., 2016; Knight, Plumb and Gorey, 2018; Lilo, 2016; Lorant et al., 2016; McKenna et al., 2014; Murphy, 2017.	Stergiopoulos et al., 2015; Young et al., 2014.	Beere et al., 2019; Miller, Rees and Buckingham, 2014.

3.2 Themes and the Corresponding Primary Research Articles

The examination of the selected articles incorporated both health and social care and identified five main themes at the heart of good integrated care for people with mental health problems. The main themes are integrate mental health into primary care, integrate physical health and mental health services, engage with service users' lived experiences, socio-economic status and policy. These were used as a guiding framework to explore the elements of interventions or care models.

The majority of service models were multi-component programmes that featured two or more of the previously established characteristics as enablers of integrated care (Mental Health Foundation, 2013). In the United States, the United Kingdom, Poland and Vietnam, the majority of programmes were in the community and/or secondary care mental health settings. Few were thoroughly detailed, and even fewer were closely investigated, raising doubts about the replicability and generalisability of most of the extant data. Sub-themes were identified under some of these themes and these are discussed below. A model (Figure 3.2) has been developed that depicts the interplay between the various themes and supports the current paper's results.

Figure 3.2 Conceptual Model of Integrating Care with Mental Health



3.2.1 Integrating Mental Health into Primary Care

The following eight articles (Table 3.6) reviewed described both barriers to and facilitators of the integration of mental health services into primary care.

Table 3.6 Articles Referring to Integrating Mental Health into Primary Care

Author (year) Country	Study Design and Data Source	Participants	Findings related to the aims of the current review	Conclusions
Bauer et al., (2013) US	Data from a patient registry was analysed using observational methods. Bivariate correlations between suicidal ideation and demographic and clinical variables, treatment process variables, and depressive outcomes were investigated using chi-squared analysis (for categorical variables) and the analysis of variance (for continuous measures).	All patients aged 18 and up who registered in the Mental Health Integration Program (MHIP) before October 31, 2010 (N = 11,155).	MHIP has already given management to thousands of people, making it a suitable model for the integrated treatment of mental health patients in primary care settings.	Many community health centres will use instruments like the PHQ-9 to help with patient management as they add behavioural health therapy to their offerings.
Cybulski et al., (2017) Poland	Microsoft Excel 2013 was used to handle the data, and Statistical Data Miner CQC PL was used to do statistical analysis.	300 people over the age of 60 from Bialystok and its environs: 100 nursing home residents, 100 senior students from Bialystok's University	The study found that social and demographic factors (such as gender, group affiliation, and age) had no bearing on the	After dementia, depression is the leading cause of increasing healthcare expenses among the elderly.

Author (year) Country	Study Design and Data Source	Participants	Findings related to the aims of the current review	Conclusions
		of the Third Age, and 100 senior students from the University of a Healthy Senior.	prevalence of depressed and non-psychotic mental symptoms.	
Gupta et al., (2018) UK	In collaboration with the mental health charity ETHICS and the Royal College of General Practitioners, the London Journal of Primary Care (LJPC) participated in a Think Tank to discover things that primary care can do to promote excellent mental health throughout the population. This document explains how general practices in the NHS can put these ideas into action.	Primary care practitioners	For the 17.6 percent of people who have a mental illness at any time, including those who also have a mental health problem among the 30 percent who report having a long-term ailment of any type, targeted care is required.	Primary care practitioners may contribute to the formation of health alliances at four different levels: as individuals, organisations, geographic clusters of organisations, and policymakers.
Lin et al., (2011) US	A retrospective cross-sectional study. Statistical analysis and logistics regression models were used.	As of January 1, 2005, Massachusetts Medicare and Medicaid	In community-dwelling older persons with mental illness and/or SUD	Improving care coordination across the physical, mental, and

Author (year) Country	Study Design and Data Source	Participants	Findings related to the aims of the current review	Conclusions
		recipients aged 65 and up (N = 679,182).	(substance use disorder), the burden of medical comorbidity is significantly higher than in those without these disorders.	addiction healthcare delivery sectors is critical.
Murphy et al., (2017) Vietnam	A cluster-randomised, stepped-wedge controlled trial was used in this study. Statistical analysis.	In 32 communes across eight Vietnamese provinces, adult patients over the age of 18 were treated.	Raise community awareness about the availability of depression support services in primary care.	There is a pressing need to expand community-based depression treatment.
Padwa et al., (2016) US	Mixed methodology. Discussions and correspondences. Focus Groups and Surveys. Content Analysis.	Three primary care clinic organisations.	When primary care clinics were given support, such as evaluation, training, and technical assistance services,	Rather than striving for high levels of integration, primary care organisations may find it more practical to try to

Author (year) Country	Study Design and Data Source	Participants	Findings related to the aims of the current review	Conclusions
			they were able to score higher on integrated care capacity assessments over time.	‘get to capable’ levels of integrated care capacity.
Samuels et al., (2015) US	Mixed methodology. Survey and interview.	An academically affiliated primary care practice that serves older adults in the city. (N = 107 people)	Screening older primary care patients for anxiety and depression was a good idea.	More research is needed to evaluate the screening process for other psychiatric disorders as well as the treatment.
Scharf et al., (2016) US	Quasi-experimental, difference-in-differences design. Difference-in-differences analyses to estimate the average treatment effect.	Across the three intervention sites, 1,049 consumers enrolled.	Because of lifestyle factors, poverty, limited access to healthy food and the use of psychotropic medications, serious mental illness is linked to an increased risk of obesity.	The findings do not apply to all adults in community mental health centres who have a serious mental illness.

According to the World Health Organisation and World Organisation of National Colleges Academies and Academic Associations of General Practitioners/Family Physicians (2008), up to 60 percent of individuals who visit primary care clinics have a diagnosable mental condition. The WHO and the World Organization of Family Doctors (WONCA) collaborated on a paper on integrating mental health into primary care (Funk et al., 2008), which outlined the reason and benefits of offering mental health treatments in primary care. Simultaneously, it offered guidance on how to adopt and scale up primary care for mental health and discussed how a variety of health systems have undertaken this transformation successfully. The most realistic option to close the treatment gap and ensure that people receive the mental health care they require is to integrate mental health services into primary care (World Health Organisation and World Organisation of National Colleges Academies and Academic Associations of General Practitioners/Family Physicians, 2008). 'How primary care can contribute to good mental health in adults', an article published in the London Journal of Primary Care (LJPC) (Gupta et al., 2018), describes how primary care practitioners operate at four different levels – as individual practitioners, organisations, geographic clusters of organisations, and policymakers.

The three sub-themes derived from the theme of integrating mental health into primary care are: reducing inequalities for older adults with mental illness, behavioural health care and global models of self-management of mental illness. These are described in the following sections.

3.2.1.1 Reducing Inequalities for Older Adults with Mental Illness

Reducing inequities for older individuals with mental illness is the first sub-theme of integrating mental health into primary care. Mentally ill older persons, especially those from low-income and minority groups, are less likely to obtain care than the general population. Despite an increasing emphasis on the significance of integrating mental health treatments into primary care settings, there has also been an increase in the attention paid to primary care facilities as locations for mental health care integration. Providing a way to assist in filling the gap in mental health care for vulnerable groups, particularly older adults, is a once-in-a-lifetime opportunity (Alexopoulos et al., 2005).

The benefit and cost-effectiveness of integrating psychiatric treatments into primary care have reached a national consensus in the United States (Bartels et al., 2004). This study confirms that providing integrated services to older adults who do not utilise them enhances access to mental health and drug addiction services. Geriatric mental health screening was integrated into an academic medical practice serving older adults in an urban setting on the upper east side of Manhattan: a patient satisfaction survey (Samuels et al., 2015) was conducted in this setting. In a primary care geriatrics practice, the findings revealed that significant patient support existed for the implementation of a depression and anxiety screening programme on a periodic basis.

Dementia, depression, and drug and alcohol addiction are the most frequent mental illnesses among the elderly, according to WHO data (Rahman et al., 2013). The purpose of a study (Cybulski et al., 2017) that included 300 inhabitants of Bialystok and its surroundings in Poland was to subjectively assess the mental health status (the severity of non-psychotic symptoms of mental functioning and depressive symptoms) in older people. The study included 300 individuals over the age of 60, including 100 nursing home residents, 100 senior students from the University of the Third Age in Bialystok, and 100 senior students from the University of a Healthy Senior in Bialystok. The outcomes of the study demonstrated that older people's subjective assessments of their mental health were unfavourable, i.e., not highly accepted. In terms of a subjective evaluation of their mental health, residents of the nursing home (N = 100) were categorised adversely.

Professional geropsychology was formally classified as a speciality of professional psychology by the American Psychological Association in late 2010. Due to their special expertise and capabilities, psychologists who work with older people have been given the chance and obligation to influence the route of healthcare reform (Mancini et al., 2009). Despite the fact that persons over the age of 65 are the fastest-growing age group in the United States, the number of professionals who specialise in gerontological health and social care services has not increased to meet the need. In response to the low workforce-to-need ratio, two public health initiatives were set in motion: (a) the implementation of integrated care models as a way of improving mental health care quality and access, and (b) the Institute of Medicine's focus on the mental health needs of older adults and workforce demands (Mental Health Weekly, 2008).

A vast amount of data shows that people with mental illnesses have a substantially greater risk of medical comorbidity than people without mental illnesses (Mertens et al., 2003). Furthermore, those who have both mental illness and SUDs are far more likely to have medical comorbidities than people who have just mental illness or SUDs (Dickey et al., 2002). Lin et al. (2011) conducted a retrospective cross-sectional study of Massachusetts Medicare and Medicaid members aged 65 and older to investigate the link between mental illness and chronic physical conditions in older adults and to see if co-occurring SUDs were associated with a higher risk of chronic physical conditions than mental illness alone. The findings clearly indicate that older people with mental illness or SUDs require immediate integration of general medical, mental health, and addiction treatment services.

Symptoms of psychopathology are still viewed as frightening and uncomfortable in most communities, and these beliefs frequently generate stigma and prejudice towards persons with mental health issues. In terms of societal stigma, research has found that stigmatising sentiments against people with mental illnesses are ubiquitous and widely held (Crisp et al., 2000). Despite the fact that there are several studies on mental health, research into stigma in mental health is still scarce.

South Asian groups were 37 percent less likely, Black communities were 47 percent less likely, and Chinese communities were 71 percent less likely than White immigrant communities to seek mental health therapy (Bergeron, Auger and Hamel, 2009). More research is needed to better understand how immigrant groups employ informal (e.g., social support networks) and non-mainstream mental health therapy (e.g., spiritual, cultural, and faith-based services). The present study is being carried out in a London borough where 42.91 percent of the population is from BAME communities. Ethnic minority populations are less likely to seek mental health treatment even though community mental health care is easily available to the general public.

3.2.1.2 Behavioural Health Care

Behavioural health care is the second sub-theme that emerged from the theme of integrating mental health into primary care. The majority of people with mental health and substance use (SU) difficulties in the United States do not receive treatment. The Affordable Care Act, often known as Obamacare, was signed into law on March 23, 2010, and it introduced incentives for primary care centres to begin providing behavioural health (MH and SU) therapies, thus filling the MH and SU treatment gaps (Ali et al., 2014). PBHCI (Primary and Behavioural Health Care Integration) grants were created to assist people with SMI or co-occurring SUDs in improving their overall wellness and physical health (PH) by facilitating the integration of primary care and preventative PH services into the community behavioural health centres where they already received care (Beehler and Wray, 2012).

In recent years, an increasing number of community-based primary care providers in the United States have begun to offer integrated mental health care, including therapies to address MH. In 2009, the Substance Abuse and Mental Health Services Administration (SAMHSA) in the United States launched the PBHCI grants programme (Scharf et al., 2016) to address issues of access to and quality of general medical care by promoting the integration of primary care services into community mental health settings where adults with serious mental illness already receive care (Kelly, Jorm and Wright, 2007). General medical outcomes from the Primary and Behavioural Health Care Integration Grant

Programme (Scharf et al., 2016) used a quasi-experimental difference-in-differences design to compare changes in general medical health among consumers served at three PBHCI clinics and three matched control clinics. Limitations to this study included the use of quasi-experimental locations and the possibility that the findings might not apply to other groups. To enhance the health of individuals with serious mental illness, more rigorous implementation of integrated care in community behavioural health settings may be required. Primary care providers are more critical in managing patients with suicidal ideation as the emphasis on integrating behavioural health treatments grow (Kroenke et al., 2010).

Patient Health Questionnaire-9 (PHQ-9) Item 9 (thoughts that one would be better off dead, or thoughts of injuring oneself in some way) was evaluated using observational data from a patient registry. In a primary care-based mental health programme, scores were linked to patient characteristics, management, and depression outcomes (Bauer et al., 2013). PHQ-9 Item 9 was used to measure the independent variable of suicidal ideation (Uebelacker et al., 2011). Safety-net Patients were more likely to have suicidal thoughts (referred by primary care providers for behavioural health care).

‘The Implementation of Integrated Behavioural Health Protocols in Primary Care Settings in Project Care’ (Padwa et al., 2016) was a piece of research that investigated how three primary care organisations implemented integrated care protocols. This research of a small sample of primary care organisations found that while it may be difficult or impossible for them to deliver completely integrated behavioural health services, they may enhance their integrated care capability, as evaluated by the Behavioural Health Integration in Medical Care (BHIMC). Padwa et al.'s (2016) study used a much smaller sample size than other studies, namely three primary care clinic organisations, in the evaluation of the evolution of integrated care capacity in health care settings (Chaple and Sacks, 2016 (sample size = 5); Chaple et al., 2016; McGovern et al., 2014), so it should not be assumed that the rates of increase in measured integrated care capacity reported among the sub-sample in this study would be replicable on a larger scale. Another limitation is that, while BHIMC is a good predictor of a clinic's capacity to provide integrated care, it does not allow for evaluation of integrated care quality or impact on clinical outcomes. According to the study's conclusion, the researchers hoped to use the findings to inform future integrated care research and develop more knowledge about the implementation of efforts to improve the capacity of primary care clinics in the United States to deliver integrated care services in the era of health care reform.

3.2.1.3 Global Models of Self-Management of Mental Illness

Despite the significant incidence of depression and its negative effects on quality of life, depression services are scarce in many parts of the world, especially in low- and middle-income countries (LMICs) (Mounier-Jack, Mayhew and Mays, 2017). Supported self-management for depression is a method of assisting individuals with depression in learning and using mood management strategies (Bilsker, Goldner and Anderson, 2012).

Although epidemiological research indicates that depression rates in Vietnam are comparable to world norms, depression services are severely restricted. In a feasibility survey performed in Vietnam from 2013 to 2015 (Murphy et al., 2017), a supported self-management (SSM) intervention showed promising benefits for community-dwelling people with depression. Health and social workers utilised the self-reporting questionnaire-20 to screen research participants at primary care centres and in the community (SRQ-20). Patients having a score of >7, suggesting depressed caseness, were asked to participate in the experiment in either the SSM intervention group or the better treatment as the usual control group. Participants were assessed using the WHO's Disability Assessment Scale (WHODAS 2.0) and the Cut-down, Annoyed, Guilty, Eye-opener (CAGE) Questionnaire for alcohol usage. In the Vietnamese context, this study has the potential to add to the body of knowledge on the efficacy of a validated SSM intervention for adult depression. This research will also contribute to the growing body of knowledge about the efficacy of low-cost, task-shifting treatments for use in low-resource locations where specialist mental health treatment is often limited. One limitation of the study was that it was only done in eight of Vietnam's 63 provinces, and so may not be representative of the diversity of the Vietnamese population.

3.2.2 Integrate Physical Health and Mental Health Services

People who suffer from mental illnesses have a shorter life expectancy and are in poorer physical condition than the general population. Evidence suggests that this is due to a combination of clinical risk factors, socio-economic factors, and healthcare system characteristics, including a lack of integration when several service venues are required for treatment (Elizabeth et al., 2018). Table 3.7 looks at publications that urge people to integrate their physical and mental health care.

Table 3.7 Articles Included in the Theme Integrate Physical Health and Mental Health Services

Author (year) Country	Study Design and Data Source	Participants	Findings related to the aims of the current review	Conclusions
Fullerton et al., (2018) US	Descriptive statistics were performed.	Adult Medicaid beneficiaries with a mental health condition (N = 110,247).	Expenditures on physical health emergency department visits, 30-day readmissions, and behavioural health inpatient admissions were cut.	The findings highlight the importance of a USC (usual source of care) for physical health and integrated mental health care for adults.
Meyer-Kalos et al., (2017) US	Qualitative research methods. Purposive sampling was used in three focus groups. Focus group transcripts from all three	The study included 16 assertive community treatment (ACT) professionals (N = 9 for the two multidisciplinary ACT provider groups; N = 7 for the ACT psychiatrists' group).	The emergent ideas from the focus group conversations are presented in the study: (1) obstacles faced, (2) caregiving strategies, and (3) provider recommendations.	The tactics and recommendations were divided into six categories: (1) cooperation with primary care, (2) improvements in engagement, (3) team-focused roles, (4) education and training,

Author (year) Country	Study Design and Data Source	Participants	Findings related to the aims of the current review	Conclusions
	focus groups were analysed using an inductive analytical approach.			(5) system-level barrier suggestions, and (6) systems cooperation.
Muralidharan et al., (2019) US	Living Well or an active control condition were allocated to participants at random. A chart review was used to analyse emergency room utilisation.	Adults with serious mental illness (N = 242).	A peer-co-facilitated illness self-management group was more helpful in increasing quality of life and self-management self-efficacy among individuals with serious mental illness than an active control group.	Future research should look into how to preserve and generalise benefits over time, as well as how to supplement Living Well with direct preventative health care.

Author (year) Country	Study Design and Data Source	Participants	Findings related to the aims of the current review	Conclusions
White et al., (2011) UK	A cluster randomised controlled experiment including secondary economic analysis and process observation in a single blind parallel group.	50 MHNs who had worked in a community mental health environment for at least six months and were registered with the Nursing and Midwifery Council . 250 patients who were above the age of 18, were on the MHN participant's caseload at the start of the trial and had a main diagnosis of SMI.	The HIP's piloting was successful, with mental health nurses, patients, psychiatrists, and general practitioners indicating that it was acceptable, saved time, and enhanced treatment planning and interface communication.	The planned study's major end aim, an improvement in physical-related quality of life, was meaningful to patients, caregivers, practitioners, and policymakers, and it formally evaluated the tool's therapeutic potential.
Wright-Berryman and Kim, (2016) US	Cross-sectional, survey design. Descriptive	Adults with SMI (age 18 and up) who were either new or existing patients getting care at the	The particular decision-making autonomy preferences of primary care service users with SMI should be explored by social workers and other mental and physical health	It adds to the growing body of knowledge about the requirements of persons with SMI in primary care, as well as

Author (year) Country	Study Design and Data Source	Participants	Findings related to the aims of the current review	Conclusions
	and bivariate analyses.	integrated clinic (N = 95).	practitioners and, in honouring individual choices, would result in a more person-centred care environment.	how specific circumstances influence decision-making autonomy preferences.

Patients with complex needs are frequently managed by services that are unable to address all of their demands since physical and mental health care treatments are commonly delivered separately. There is little recognition in UK policy of the complexity that occurs at the interface of services, or of the longer-term budgetary repercussions of not addressing practical alternatives to existing provision (Department of Health, 2006b). Part of the problem may be traced back to the 1990s, when acute hospital and mental health trusts were formed and treatment was commissioned separately (Department of Health, 2011).

In the United States, mental health disorders account for four of the top 10 causes of disability (National Institute of Mental Health, 2018). Despite efforts to combine physical and behavioural health care to fulfil people with SMI's primary health care needs, little is known about their health care behaviours and how they make treatment decisions. SMI (schizophrenia or bipolar disorder) patients' physical health is a serious public health problem. According to one epidemiological study, comorbid physical illness reduces life expectancy by 20-25 years in schizophrenia and 10-15 years in bipolar disorder.

Primary and secondary care have long ignored the physical health requirements of SMI patients, prompting a variety of guidelines. A cross-sectional survey design (CMHC) was used to evaluate the connection between characteristics associated with decision-making autonomy preferences for 95 adults with SMI who were treated in an integrated health care clinic onsite at a suburban Midwestern community mental health centre (Wright-Berryman and Kim, 2016). According to the study, people may have different decision-making autonomy preferences in physical health care, based on their diverse background factors. Despite its limitations, this study contributes to the body of information on the needs of people with SMI in primary care, particularly how factors such as gender and social support, as well as previous studies, impact decision-making autonomy preferences.

Meyer-Kalos et al. (2017) conducted a qualitative study to examine the perspectives of assertive community treatment (ACT) team members on the integration of physical and mental health self-management for people with SMI. Providers having an average of 14.6 years of experience dealing with people with SMI were among the participants. Participants were polled in three focus groups on hurdles, tactics, and recommendations. Six main themes emerged from inductive analyses: (1) cooperation with primary care, (2) improved engagement, (3) team-focused roles, (4) education and training, (5) solutions for system-level impediments, and (6) systems cooperation. Furthermore, the focus of this study was only on provider evaluations of client experiences. Although prior client-centred research had discovered comparable hurdles such as communication issues, stigma, and structural constraints such as transportation (Graham et al., 2013), future research should examine client views of health and wellness to acquire a more balanced opinion.

Another study (Fullerton et al., 2018) explored the influence of having a usual source of care (USC) for physical health on health care utilisation and expenditures for high-cost or unnecessary treatments, as well as health care quality, among Medicaid-eligible persons aged 19–64 years. It used administrative data (eligibility and claims files) from the Truven Health MarketScan MultiState Medicaid Database from 2011 to 2012 (Manzoli et al., 2013).

This database provides information on more than 28 million Medicaid recipients across 12 states. A range of variables might explain why a USC has a positive influence on acute care utilisation. To begin with, evidence suggests that having a primary care physician can help to overcome barriers to appropriate health care services, including outpatient therapy (Starfield, 2005). Second, having a USC is likely to encourage treatment continuity, which has been related to improved healthcare use and is particularly important for patients with complicated medical needs (Rosenblatt et al., 2000). Finally, having a USC can help with care coordination, especially if it is provided by organisations that focus on it, such as Federally Qualified Health Centers (FQHC), Medicaid Health Homes, or patient-centred medical homes. Based on these findings, policymakers and Medicaid programme managers should create policies and programmes that encourage beneficiaries with mental health disorders to contact a USC and to coordinate physical and mental health care (Blewett et al., 2008). One of the study's limitations was that USC was assessed using an administrative claims data approach based on a single physical health interaction with an outpatient physician in an outpatient, non-acute, or non-emergency environment over a 12-month period (Witt et al., 2017).

Adults with significant mental illness (N = 242) were randomly allocated to Living Well or an active control condition in a study (Muralidharan et al., 2019) to explore Living Well, an intervention to improve medical illness self-management among individuals with SMI. Peer interaction, action-planning, problem-solving skills training, weekly goal setting, and the encouragement of small efforts toward health objectives were all part of Living Well. Participation in Living Well resulted in significant improvements in mental health - but not physical health-related quality of life - immediately after treatment, as well as improvements in self-efficacy and behavioral and cognitive symptom management, according to the findings. To increase accessibility, efficacy, and generality, future research should investigate new ways to package and disseminate Living Well.

The Health Improvement Profile (HIP) for SMI is a quick and easy-to-use tool that allows mental health nurses to work with patients to assess physical health and take evidence-based action when variables are identified as being at risk. Piloting was used to determine clinical value and acceptance. The HIP is designed to fit on one side of an A4 sheet of paper and has five columns that display the variable at risk for assessment (e.g., smoking status), level (outcome), green (e.g., 'non-smoker'), red (e.g., 'passive smoker/smoker'), and the recommended action for the red group (e.g., advice that all smoking is associated with health risks, according to NHS smoking cessation service). The HIP should be completed once a year for patients with SMI as this is the recommended screening frequency (Bressington et al., 2014). To maximise success in the future deployment of the HIP, a study (White et al., 2011) was conducted utilising an education package to fulfil the individual and organisational requirements of the personnel most likely to come into contact with individuals with SMI. If the evidence is successful, it will be used to guide regional diffusion and a future conclusive effectiveness assessment, allowing policymakers to promote the HIP programme across the NHS.

3.2.3 Engaging Service Users' Lived Experiences

The published literature (Table 3.8) suggests the needs for engaging with service users in mental health provision.

Table 3.8 Articles Referring to Engaging Service Users' Lived Experiences

Author (year) Country	Study Design and Data Source	Participants	Findings related to the aims of the current review	Conclusions
Gaglioti et al., (2017) US	A retrospective cohort analysis was conducted. A generalised estimating equation technique was used to conduct the primary study of healthcare service utilisation.	Three hundred and 58 people signed up for the programme.	Patients involved in the programme were 60–70 percent less likely to visit the emergency room and 50 percent less likely to be admitted to the hospital after participation than before.Following enrolment,individual attendance at outpatient primary care and mental health visits increased.	Further research should focus on replicating this paradigm to further understand its cost-cutting and health-promoting impacts.

Author (year) Country	Study Design and Data Source	Participants	Findings related to the aims of the current review	Conclusions
Jespersen et al., (2016) Australia	Data was gathered in a variety of ways, using surveys and staff focus groups.	People with mental conditions, carers, and employees.	Alternative to crisis teams, there are other ways to deliver emergency mental health care (e.g., mental health clinicians in emergency departments).	There is a need to coordinate community and inpatient treatment alternatives, as well as treatments that are personalised to meet individual requirements and coordinated across agencies and professions.
Knight, Plumb and Gorey, (2018) Australia	To improve customer results, a regional mental health agency conducted a pilot for integrated treatment.	Clients aged 18 and up with a severe and chronic mental illness; extensive psychosocial requirements, many of which necessitate	Consumer access to psychological and rehabilitative support services grew as a result of the integration of an NGO into the therapeutic	The STARR Service is an innovative example of a non-profit collaborating with a government-run mental health service to give

Author (year) Country	Study Design and Data Source	Participants	Findings related to the aims of the current review	Conclusions
		cross-sector coordination of treatment.	environment. STARR explained how to overcome the obstacles of implementing an integrated approach.	integrated treatment, cooperation, coordination, and co-location.
Lilo, (2016) UK	Small scale front-line research projects and a national survey were used to evaluate Mersey Care, the NHS Trust's Mental Health Social Work Integrated Support and Development programme.	Service users, carers, social workers, and other professionals, as well as management, were all involved.	People who used services were typically seen as benefiting from integrated arrangements because they improved holistic care planning and reduced duplication of evaluations.	Councils are evaluating agreements and attempting to gain more control over the employment of social workers in health care teams.
Lorant et al., (2016) Belgium	An observational study was conducted.	With a total of 635 services, the individual networks featured between 14 and	Men had a greater priority than women. Patients and	Despite the fact that the reform was designed for the

Author (year) Country	Study Design and Data Source	Participants	Findings related to the aims of the current review	Conclusions
	For people with mental health issues, there are ten mental health care networks to choose from. Tabulations and chi-square tests were used to analyse the data.	140 distinct services, and all services were welcome to participate. Services were required to choose 10 users who are adults (aged 18 to 65), have psychological distress and have been in touch with the service during the data collecting period. There was no need for a formal diagnosis.	consumers of community and social services who were less socially integrated were less likely to be chosen.	entire community of individuals with mental health problems, the users chosen to fit the description of severely mentally ill people who are socially isolated and have poor social functioning.
McKenna et al., (2014) Australia	A qualitative in-depth focus group interview was used as part of an exploratory research strategy.	There were a total of 12 mental health nurses on staff. At each older adult acute inpatient facility, a 60 to 90-minute focus group was held with four mental	The findings of this study revealed areas of strength in nursing practice as well as areas of doubt in	To effectively establish a recovery-orientated paradigm, a coordinated effort focused on recovery education is necessary, including

Author (year) Country	Study Design and Data Source	Participants	Findings related to the aims of the current review	Conclusions
	The qualitative data were analysed using a standard inductive methodology.	health nurses and one researcher.	recovery-orientated care.	an examination of the barriers to recovery-orientated treatment in older adult acute inpatient settings.
Murphy, (2017) UK	Qualitative methodology. Interviews were conducted and analysed using interpretative phenomenological analysis.	Four service-users.	It was difficult to distinguish risk assessment from other components of mental health care because it was so ingrained in daily practice.	Considerations of the use of risk assessment terminology, as well as concerns of trust and authority in the therapeutic relationship, were all clinical implications.

Gaglioti et al. (2017) studied 358 adult, non-pregnant, English-speaking patients who were part of an interprofessional, integrated care management programme at an academic health centre (AHC) in Iowa. The programme, for people with persistent mental and physical health issues, was launched as part of a curriculum for family medicine and family medicine psychiatry residents. It was unable to ascertain if specific members of the cohort with certain conditions had differential usage patterns since the patient registry did not identify which inclusion criteria each patient met; participants in the programme commonly fell into more than one of the enrolling categories. The findings supported the clinical efficacy of an integrated care management approach for patients with chronic behavioural and physical health concerns, and they emerged at a good moment given the current effort in the United States to combine behavioural health and general care (McGough et al., 2016).

Integration in mental health is confronting unprecedented problems, according to a study in the UK (Lilo, 2016). Local governments are increasingly doubting its worth, claiming that it has harmed their staff's capacity to perform fundamental local government functions, such as social care assessment of need, personalisation, and safeguarding. Another study (Murphy, 2017) sought to elucidate individuals' lived experiences of risk assessment in the context of developing and maintaining therapeutic relationships in a Community Mental Health Recovery Service (CMHRS), to answer the research question: How do service users experience risk assessment in the context of developing and maintaining therapeutic relationships in a Community Mental Health Recovery Service? Positive risk and strengths evaluation has not received nearly as much attention as negative risk assessment (Langan, 2010), and it is an area where further investigation is needed. This study has provided qualitative, lived-experience data from the perspective of the service-user, and it could be expanded in the future by looking at the relationships between risk assessment and the therapeutic relationship of using quantitative measures. Further study into these areas may possibly yield data that might be used to guide service development decisions.

Belgium is now undertaking a national mental health care delivery reform based on service networks, which translates into integrated systems (Lorant et al., 2016). These networks are intended to promote community-based care delivery, reduce hospital admissions, and increase care continuity. The relevance of addressing the mental health of a specific set of patients, namely working-age adults, was demonstrated in this study. The article ‘A STARR is Born! A shining example of Integrated

Care' (Knight, Plumb and Gorey, 2018) shows how the hurdles of implementing an integrated approach may be overcome (World Health Organisation, 2016). The Support Time and Rehabilitation Recovery Service (STARR), which is delivered by a contracted non-government organisation (NGO) in collaboration with doctors, was sponsored by Queensland Health in 2016.

Nurses in a study titled Recovery-Orientated Care in Older Adult Acute Inpatient Mental Health Settings in Australia: An Exploratory Study (McKenna et al., 2014) described the benefits of collaborative care, which improves community care once inpatient units are discharged (Lim et al., 2017). Self-management has been recommended as a way for older persons with mental illness and cognitive decline to increase their community involvement and citizenship (McKenna et al., 2014). The pragmatic approaches suggested by nurses in this study to encourage and improve autonomy and self-determination may aid rehabilitation after discharge. Future research should be longitudinal to accurately capture the influence of models of care on the whole of the journey experienced as recovery-orientated settings grow over the life span. Furthermore, the policy-driven model of rehabilitation, which takes a one-size-fits-all approach, must be addressed in the context of older adults with mental health and physical health issues.

Another piece of research, The Impact of Integrating Crisis Teams into Community Mental Health Services on Emergency Department and Inpatient Demand (Jespersen et al., 2016), was conducted in an Australian public health system. The findings of the study reveal that there is a dearth of evidence which community mental health service administrators may use to make decisions regarding the merits of one type of treatment over another. According to Muir-Cochrane's review (Muir-Cochrane, 2001), community and inpatient treatment choices must be integrated, and treatments must be customised to individual requirements and coordinated across agencies and professions. The study's aim of creating a seamless model of treatment demonstrates that acute treatment may be offered in both the community and emergency departments without the need for community crisis teams or an increase in the number of emergency department presentations with mental health issues.

3.2.4 Socio-Economic Status

Numerous studies have revealed a link between socio-economic positions and mental health across the globe. Mental illness is more common in communities with lower socio-economic status (SES), although no clear causative factors have been discovered. The following two research findings reveal a link between mental health and one of the socio-economic categories, homelessness (Table 3.9).

Table 3.9 Articles on Socio-Economic Status

Author (year) Country	Study Design and Data Source	Participants	Findings related to the aims of the current review	Conclusions
Stergiopoulos et al., (2015) US	Quasi-experimental investigation. Analytical statistics. To compare baseline characteristics of individuals, chi-square tests were used.	142 participants.	Improvements in community functioning, residential stability, hospitalisations and emergency department visits, with no significant changes in these outcome variables across groups over time.	Individuals facing homelessness and mental illness may benefit from shelter-based collaborative mental health treatment approaches. Future research should validate these findings and look at the cost-effectiveness of collaborative care approaches in this demographic.
Young et al., (2014) US	SPSS 19 was used to conduct the analysis.	Adults with a history of long-term homelessness and co-occurring mental health and drug abuse issues (N = 60).	Although there were no changes in drug use, there were statistically significant improvements in mental health symptomatology and residential stability over time.	The intervention's effectiveness in terms of increasing mental health and housing stability in persons with complex behavioural health and housing requirements.

Individuals and society alike suffer from poor mental health, which has significant social and economic ramifications. Poor social support, feelings of being belittled, poor employment status (getting a disability benefit and unemployment), economic hardship, crucial life events, and functional impairment were all substantially and independently linked to mental health symptoms. When compared to those who are housed, the incidence of major mental illness is greater among the homeless, as are the rates of personality disorder, self-harm, and attempted suicide. Homeless people are more likely to develop physical and mental illnesses. The majority of these illnesses are curable, but homeless people are less likely to seek medical help, resulting in high death rates. There is little doubt that much more can be done to enhance homeless people's care and access to services (Perry and Craig, 2015).

3.2.4.1 Homelessness

Homelessness is a serious societal issue in North America, with an estimated 150,000 people in Canada and 1.4 million in the United States suffering homelessness each year. Approximately 28,000 people visited emergency shelters in Toronto, Canada's largest city, in 2008, with single males outnumbering single women, with these males using 70 percent of the beds compared to 29 percent for the women. For 142 men experiencing homelessness and mental illness, a quasi-experimental study (Stergiopoulos et al., 2015) compared the outcomes of two shelter-based collaborative mental health care models: (1) an integrated multidisciplinary collaborative care (IMCC) model and (2) a less resource-intensive shifted outpatient collaborative care (SOCC) model. On measures of community functioning, residential stability, hospitalisations, emergency department visits, and community physician visits, both programmes improved with time, with no significant differences between groups on these end measures. This suggests that shelter-based collaborative mental health treatment approaches might be beneficial to those who are homeless and suffering from mental illness. Future research should validate these findings and investigate the cost-effectiveness of collaborative care approaches for this group.

ACT is a service delivery framework that emphasises community-based services, assertive engagement, high-intensity services, small caseloads, 24-hour accountability, a team approach, a multidisciplinary team, close collaboration with the support system, and staffing consistency. ACT is not a therapeutic intervention in and of itself; rather, it is a method of arranging services to give vital assistance for clients with severe mental illness to integrate into their communities (DeLuca, Moser and Bond, 2008). Adults with complicated behavioural health and housing issues have found that assertive community ACT and integrated dual disorders treatment (IDDT) are both effective treatments. In a US study (Young et al., 2014), 60 people with a history of chronic homelessness and co-occurring mental health and drug use disorders (COD) were attended to by an ACT team that administered integrated treatment based on IDDT principles to people with COD who were chronically homeless. The findings supported the intervention's effectiveness in reducing participants' mental health symptom severity and frequency of mental health concerns. As a result of the intervention, participants reported higher rates of independent stable housing (i.e., living in one's own house or apartment) and lower rates of real homelessness (i.e., living on the streets, in public places, in an automobile, or in sheltered types accommodations). Prior research on I-ACT therapy has revealed that the first 6–12 months are critical for change (Fletcher et al., 2008). The current study's 6-month follow-up results (Young et al., 2014) corroborate Fletcher et al.(2008)'s findings in terms of improved housing and mental health, but it failed to find statistically significant changes in drug use. As ACT programmes are generally intense and serve a small number of people, future research should strive to replicate these findings with larger samples and longer follow-up periods.

Despite the fact that no current studies have evaluated the mental health of the homeless population, ACT has suffered widespread disinvestment in recent years, with many teams being combined into generic CMHTs (Edwards et al., 2016). Such changes have been criticised for moving away from evidence-based systems and, instead, embracing unproven service delivery methods that result in lower-quality treatment, as documented in a King's Fund report (Gilburt et al., 2013). In certain situations, new programmes have adopted a flexible ACT (FACT) approach, allowing clients to get intensive assistance in the community as needed, employing a team caseload and ACT principles (Nugter et al., 2016). Following service reconfiguration to three FACT teams, an observational study, Flexible Assertive Community Treatment (FACT) Model in Specialist Psychosis Teams: An Evaluation (Sood et al., 2017), was conducted with 380 people from three CMHTs and 95 people from an ACT team, all with a history of psychosis. Due to the reduced requirement for acute (crisis resolution and intensive home treatment service and inpatient) treatment, this study indicated that FACT may be a superior approach for persons with a history of psychosis than typical CMHT treatment.

3.2.5 Policy

All signs point to mental health continuing to be high on the policy (Table 3.10) and legislative agenda, but questions remain about whether governments around the world are committed to implementing preventative measures to adequately preserve their nation's mental health.

Table 3.10 Articles on policy

Author (year) Country	Study Design and Data Source.	Participants	Findings related to the aims of the current review	Conclusions
Beere et al., (2019) Australia	Mixed-methods evaluation carried out independently. Meetings of the Governance Committee and programme paperwork (the initial financing request, the funding contract and subcontracts, memoranda of understanding, and Floresco's practice manual) (meeting papers for the period mid-2014 to March 2018, and observations and notes taken at meetings between mid-2015 and March 2018).	Aftercare managers involved in establishing and overseeing Floresco (4), Floresco staff (4), support workers employed by consortium partners (3), consortium partner managers (4), private practitioners (2), Mental Health Service (MHS) staff (5), and Floresco Governance Committee members were among the consenting participants (some holding multiple roles) (10).	In terms of more effective use of scarce hospital and MHS resources, the Floresco service model has the potential to enhance system results.	In the Australian mental health service landscape, where there are so many different funders and providers, implementing a new integrated model is difficult. However, it also demonstrates that NGO and private practitioner services may be integrated horizontally with public mental health services.

Author (year) Country	Study Design and Data Source.	Participants	Findings related to the aims of the current review	Conclusions
Miller, Rees and Buckingham, (2014) UK	In-depth semi-structured interviews with a purposeful sample of third-sector organisations and public sector commissioners with responsibility for mental health services in the case study regions, as well as a survey of TSOs. The interviews and survey data were analysed using framework analysis, which included both deductive and inductive topics.	Three English local authority regions were studied, with the help of TSOs.	Commissioners' ability to utilise their buying power to urge improved integration was hampered by the public sector health care providers' market dominance and their inability to focus on smaller-scale integration prospects. Structures and processes for commissioning were not perceived as being integrated, with silo functioning amongst public sector entities.	The difficulties of seeking to employ market forms of governance to achieve more integrated care was highlighted.

In ‘You can't buy me love, but can you buy me integration?', Miller, Rees and Buckingham (2014) used the example of English Mental Health Services to investigate the implementation of commissioning in adult mental health. It was based in three English local authority regions and drew on TSOs’ experiences with public-sector commissioning. All TSOs in the case study regions who characterised themselves as having a special focus on responding to the needs of persons with mental health difficulties were asked to complete a survey. Semi-structured interviews with a purposive sample of TSOs were then conducted to further investigate the survey's findings. Interviews with public sector commissioners in charge of mental health services in the case study locations were also conducted. The interviews and survey data were analysed using framework analysis, which examined both deductive and inductive topics.

Commissioning structures and procedures were not regarded to be integrated, with symptoms of silo functioning across public sector units and even within the same organisation. This study highlights the challenges of attempting to use market-based governance to promote more integrated care. According to larger procurement theory, the effectiveness of the process is influenced by the transaction costs of maintaining a supply chain, opinions on what constitutes ‘value for money’, and the degree of trust or opportunism within the provider-purchaser relationship. However, it appears that public monies might be used to stimulate new ways of integration provided there is adequate procurement capacity and knowledge, as well as a collaborative process in which partners take individual risks in the hopes of benefiting patients and service users.

The Floresco integrated service model was developed to overcome disparities in community mental health treatment and support services. Floresco was created in Queensland, Australia, by a collection of non-government organisations that sought to establish a ‘one-stop’ mental health service centre by collaborating with GPs, private mental health providers, and public mental health services. In a mixed-methods study of an integrated adult mental health care model, staff commitment, co-location of services, flexibility in problem-solving, and anecdotal evidence of positive client outcomes were identified as important facilitators of service integration (Beere et al., 2019). Different organisational methods, difficulties communicating information, attracting and keeping GPs and private practitioners, and institutional limitations on integration with public mental health treatment were all obstacles to integration. Despite the lack of a control group and a small follow-up sample size, Floresco's integrated service approach appeared to improve client outcomes while it lowered the burden on the public mental health system. Non-government and commercial services were horizontally integrated, and substantial progress was made towards integration with public mental health treatment.

3.3 Chapter Summary

This review aimed to understand what evidence is currently available on the extent to which integrated care programmes help mental health service users. The findings of this literature review on integrated health care for adult mental health highlight the perceived importance of collaboration between primary care and mental health services, multidisciplinary teams, socio-economic factors, the role of policies to support collaboration, staff willingness to participate in various types of collaborative initiatives, and the perceived efficacy of collaborative initiatives. Despite this, there are still a number of impediments to effective cross-sector collaboration, most notably professional and structural concerns. These are the main concepts that this case study might be based on. More study and further examination of the success of each of these efforts in terms of enhancing cooperation and mental health and social outcomes are needed, however, to achieve the greatest possible outcomes for service users and sector personnel.

A significant number of research articles evaluating integrated mental health care approaches are available, especially from US and UK. The authors present a continuum of integration between main and specialist services, ranging from somewhat unintegrated settings in which specialists run outpatient clinics at health centres (with minimal interaction with primary care workers) to extremely sophisticated integrated modes of functioning (with high-level interaction, formalised and informal communication between primary and specialist colleagues). When new models of primary care for mental health are established, the evidence suggests that adequate training, both formal and informal, should be evaluated for all primary care professionals, not only GPs. Knowledge exchange through systematic instruction and time-limited case-based conferences, for example, was a clearly perceived advantage highlighted in several studies, developing and solidifying ties between diverse care providers and breaking down care silos. There are numerous papers on health and social care integration and integrated care in general and mental health services, but there are relatively few on their collaboration. This analysis has identified several topics for further study, including integrated treatment for people with mental health concerns and mental health care for black and minority ethnic groups in the UK. Adults above the age of 18 are the target audience for this study. This study has identified a study deficit regarding the determination if people with significant and long-term mental illness can maintain social inclusion without the assistance of care coordinators/navigators.

Another research gap identified by this review is the development of staff involvement. To achieve high levels of engagement, an organisation must make a concerted effort across the board, which may include adjustments to leadership styles, team behaviours, and individual responsibilities. The duties of leaders, the authority provided to front-line workers, the relevance of values and integrity, and the necessity for a degree of stability and continuity for leaders and workers to establish a high engagement model are all issues that need to be highlighted for future research. Finally, further research is needed to define valid criteria for release from specialist services back to the community, as well as integrated care outcome measures: In the literature studied, both are varied in nature.

It is unlikely that any one model will be a one-size-fits-all solution. Rather, for different demographic and geographical locations, major component ‘gold standard’ elements and ‘themes’ will need to be examined, guided by existing scientific information, and an understanding of local population requirements and available resources. Regardless of which model or component elements are chosen, the literature indicates that for any project to be successful, meticulous planning and a clear execution strategy must be agreed upon from the beginning. Although this review has discussed five papers from the UK, most of the research comes from other settings, predominantly the US (N = 12), which has very different health care systems to the UK. Thus, such findings may have limited applicability for UK health, social care and third sector services. Therefore, my study is needed to understand the implications of mental health provisions by the collaborative working of NHS, local council and voluntary sector organisations.

CHAPTER 4: METHODOLOGY

4.1 Introduction

The preceding chapter identified a gap in the research in the area of health and social care integration in mental health care in the United Kingdom and around the world. The literature evaluation allowed several potential study areas to be investigated further. However, to maintain a consistent study design, a knowledge of the philosophical viewpoint is essential before such judgements can be made (Mason, 2017; Koro-Ljungberg, 2008; Denzin and Lincoln, 2018). The social researcher has access to a wide range of methods and methodologies (Bickman and Rog, 2009), and it is critical to establish a good theoretical framework from which to guide, support, and perform any doctoral study (Grant and Osanloo, 2014).

In seeking to understand how the integration agenda facilitates improvements in the mental health of the population, a study that explores personal constructions of the leadership team, operational staff and service users would provide new meaning for the mental health provision within the integrated care system. This chapter presents a summary of the case study technique and approach used in this research project, as well as the context and justification for the study. This section also explores the epistemological and ontological perspective of social constructionism regarding mental illness. It offers an overview of the thematic qualitative data analysis employed and its relationship to the study aims and objectives. It also covers the unique strategy to data collecting, the sample, and the methodologies utilised to gather and analyse the data.

4.2 Research Design

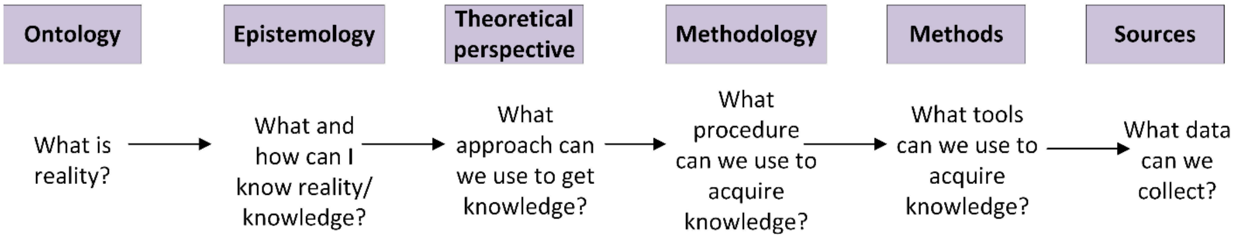
Social research methods are not neutral instruments; they are intertwined with various conceptions of how social reality should be researched (Bryman, 2008) and, as a result, rely on various theoretical perspectives. Before beginning any endeavour, researchers should be precise and open about their ontological and epistemological assumptions (Guba and Lincoln, 1994) cited in (Andrade, 2009). Some authors (Cecez-Kecmanovic and Kennan, 2013; Garcia and Quek, 1997) cited in (Dobson and Love, 2004) indicate that philosophical and theoretical assumptions should constitute the beginning for the methodology choice and offer early guidance for the research process.

Social science research is often affected by what are referred to as paradigms, whether overtly or implicitly. There is no universally accepted definition of the term *paradigm* (Anohah, 2017). Kuhn

(1970), cited in (Mingers, 2004) coined the term to describe a broad underlying theoretical and conceptual framework (e.g. Newtonian physics) that is not challenged in ‘normal’ scientific activity. All actual experimentation is thought to be guided by this framework. A paradigm is said to emerge from a high level of professional consensus among scientific researchers on aspects of theories, research standards, and established findings; it also includes aspects of fundamental philosophical beliefs (Anohah, 2017).

As shown in Figure 4.1, this section draws on the work of Mason (2002) and Grix (2002), who discuss the two philosophical concepts of ontology (what exists in the world) and epistemology (how knowledge is obtained about what exists in the world), emphasising the relationship between qualitative research and the search for knowledge within the field of study.

Figure 4.1 Relationship between Ontology, Epistemology, Methodology, Methods and Sources (Adapted from Grix (2001))



The study of being is known as ontology (Crotty, 1998, p. 10). Ontological assumptions are concerned with what constitutes reality: in other words, what is. Researchers must take a stand on their perceptions of how things are and how they work in the real world. Epistemology, on the other hand, is concerned with the nature and forms of knowledge (Cohen, Manion and Morrison, 2007). Guba and Lincoln (1994) explain that epistemology asks the question: What is the nature of the relationship between the *would-be knower* and *what can be known*?

A theoretical framework will operate as the basis from which all knowledge is formed once we have established how we know what we know via epistemology (metaphorically and literally). Grix (2002) goes on to cover methodology, methods and sources (Figure 4.1), all of which are influenced by ontological and epistemological viewpoints, as well as the project's theoretical foundations. This study's general methodology is guided by an interpretative understanding (Webb and Kevern, 2001); as a result, it leans on the philosophy of social constructionism to provide a framework for analysis.

4.2.1 Social Constructionism

A social constructionist theoretical framework and an interpretivist epistemology underpin the present research, both of which are concerned with social interaction, social experience, and how everyday meaning is created from these encounters (Crotty, 1998; Berger and Luckmann, 1991). The debate between positivism and interpretivism stretches back to at least the mid-nineteenth century when the interpretivist paradigm evolved in contrast to positivism in an attempt to grasp and explain human and social reality (Pather and Remenyi, 2005). It is frequently linked to Wilhelm Dilthey's claim (later picked up by Max Weber) that human phenomena must be understood in their social and cultural contexts, and that the task of the social sciences is to *verstehen*, to recognise meanings, to comprehend, as opposed to *erklären*, to explain, to focus on causality, which is the approach of the natural sciences (Crotty, 1998; Johnson and Duberley, 2011; Willis, 2007).

According to (Walsham, 1995: p. 376),

'... interpretive methods of research adopt the position that knowledge of a reality is a social construction by human factors. In this view, value-free data cannot be obtained since the enquirer uses his or her preconceptions in order to guide the process of enquiry, and furthermore, the researcher interacts with the human subjects of the enquiry, changing the perceptions of both parties'.

The implication here is that not merely social reality but "all meaningful reality, precisely as meaningful reality, is socially constructed" (Crotty, 1998, p.55).

The rejection of positivism and the belief that all knowledge is a product of the social context in which the actors live is at the heart of social constructionism. The goal of social constructionism is to figure out how people and communities contribute to the construction of their own world (Burr, 2015). Despite the fact that epistemology and ontology are distinct concepts with their own impact on social inquiry, they are frequently combined as the fundamental concepts that support all social research (Thomas and Harden, 2008). To clarify my position regarding the current research and to select the most appropriate research approach to anchor and shape this thesis, I used the ontological and epistemological assumptions that support the major paradigms. Ontology is concerned with the nature of reality and what can be known about it, whereas epistemology is concerned with the concept of what can be known, comprehending reality, and the nature and processes of knowledge generation (Scotland, 2012; Braun and Clarke, 2013).

Individuals would have had a varied social and cultural experience of the mental health care programme, which is a component of Berger and Luckmann's (1991) social construction of reality. To fulfil the aim of the research, a qualitative approach was embraced to collect the sort of data that would allow for a more in-depth understanding of the leadership team and staff's everyday interactions and how they influence their work lives. It was uncertain what may be found on entering the research environment; therefore, a qualitative research approach was best suited for this. As a result, an exploratory strategy was taken, for which (Silverman, 2011) believes qualitative research is the best option.

The topic of cultural barriers is especially relevant in the present atmosphere of change in health and social care, and it may have a meaningful influence on how professionals collaborate, as evidenced by the findings of this study. The current study was developed using social constructionism as a guide. Finding a place for the research inside a research paradigm was difficult at first, and the perspective has grown and altered as the experience has progressed. After experiencing the nature of health and social care within *The Collaborative* from the perspective of a researcher, there is a greater understanding of the importance of social interaction, and how it influenced not only *The Collaborative*'s operation and community teamwork, but also how relationships between different professions impacted day-to-day work. Although each profession has its own culture, various individuals within those professions contribute their own socialisation, personality, and culture to the profession (Adams et al., 2006), which will be discussed in the results chapter. I studied Crotty (1998) early in my PhD studies in an attempt to situate myself inside a research paradigm, but after experiencing the setting and the significance of social interaction within it, I re-read the chapter on constructionism and finally grasped the alignment that occurred. According to Crotty, constructionism is inherently both objective and subjective, an effect which is amplified in this study.

The outcomes of this investigation will be analysed by collecting information from the directors, professionals, and staff. According to Burr (2015), social constructionism is the process of extracting meaning from situations, events, and experiences. It is an effort to understand the nature of reality via a social lens. Berger and Luckmann (1966) claim that all information is derived from and sustained through social interactions, even the most fundamental basic or ‘common sense’ information. According to Collin (1997, p.2-3):

'our perception of the material world is affected by the way we think or talk about it, by our consensus about its nature, by the way we explain it to each other and by the concepts we use to grasp it'.

The concept of objective truth is questioned by social constructionism. There is an emphasis on the contingent basis of reality (Lupton, 1994). There is also a rejection of the idea that facts are 'given' and can only be discovered via scientific inquiry. Instead, the emphasis is on wider social processes, different realities, and the significance of social, cultural, and political circumstances. This approach is understood in this thesis as a manner of assessing the many realities and explanations that exist while considering mental illness provisions. According to Burr (1995, p.3), social constructionism permits us to take a 'critical posture against our accepted methods of perceiving the world'. As Burr (2000, p.4) points out, beliefs about health and sickness in the community might be understood for their intrinsic value:

'... all ways of understanding are historically and culturally relative. The particular forms of knowledge that abound in any culture are, therefore, artefacts of it, and we should not assume that our ways of understanding are necessarily any better (in terms of being nearer the truth) than any other ways'.

The use of social constructionism as a theoretical framework for exploring and considering leadership knowledge from semi-structured interview data is appropriate because it allows the individual's voice to be considered alongside that of the focus group data of 'professionals' and 'staff' of 'equal' worth, value, and status. Rather than being an add-on or an afterthought to professional knowledge, this information may be defended as genuine and complicated in contrast to the knowledge of the many professions.

Reality is produced *'in and out of interaction between human beings and their surroundings, and evolved and transmitted within a basically social framework,',* according to Crotty (1998, p.4). As it is diametrically opposed to empiricism, science and the tangible world, social constructionism has been chastised for its dependence on relativity. Indeed, social constructionism may be nothing more than a construct and a different type of knowledge.

Burr (1995) supports this idea by claiming that most knowledge of the world comes through human experience, which is impacted by language. Language, as a vehicle for symbols, is fundamental to the social production of reality in this notion, as is symbolism. We facilitate the formation of themes by giving front-line staff a voice and enable them to articulate their thoughts through narratives and discursive techniques. The subjective voice's emergence and facilitation enable an individual to communicate his or her knowledge and views about their objective social reality.

According to Jokinen, Juhila and Tarja (1999), social constructionism is an important and useful framework for investigating social work (such as that of *The Collaborative*'s mental health directors) and is an activity that helps to create reality and emphasises how any reality is defined, both through and in activity. As the study uses documentary analysis and builds up scenarios, this exploratory research will be characterised by inductive reasoning (Goddard and Melville, 2004). The inductive approach typically includes coding by a consensus process, which includes one or both of the following activities: 1) regular meetings among coders to discuss procedures for assigning codes to segments of data and resolve differences in coding procedures, and 2) a comparison of codes assigned to selected transcripts to calculate a percent agreement or kappa measure of inter-rater reliability. The first technique is employed in this study as it is used in most research in the mental health services literature (Gilburt et al., 2013; Mittal et al., 2013).

4.3 Methodology

Methodology is the strategy or plan of action that guides the selection and application of certain procedures (Crotty, 1998, p.3). Thus, methodology addresses why, what, where, when, and how data is collected and analysed. Methodology is the intellectual framework within or the basis upon which research is conducted (Brown, 2006).

4.3.1 Case Study Methodology

The approach that enables a case study to capture the complexity of a single example has emerged from the social sciences, not just in the social sciences like psychology, sociology, anthropology or economics but also in practice-orientated domains, like environmental studies, education, and business studies (Johansson, 2003).

Case study research is an established approach that has been formally defined as involving:

'An empirical study that investigates a contemporary phenomenon within its real-life context, when the boundaries between phenomenon and context are not clearly evident and in which multiple sources of evidence are used' (Yin, 1994, p.23).

The case study that served as the basis for this thesis relied heavily on qualitative semi-structured interviews and focus groups, both of which will be discussed in greater depth later in this chapter. A case study can be defined in a variety of ways. Case study researchers (Yin, 2014; Merriam and Tisdell, 2015; Stake, 1995; Miles, Huberman and Saldaña, 2014; Gillham, 2010) have emphasised when a 'case' should be studied and what form it should take. A 'case' should be

- a complex functioning unit,
- investigated in its natural context with a multitude of methods, and
- contemporary.

Case studies have been extensively defined by Yin (1989) in terms of the types of issues and questions they may address. He outlined three requirements that would indicate if a case study technique or another approach, such as an experiment, a survey, or a history, was acceptable. The form of study question offered was the first of these criteria. Although Yin believed that case studies were best suited to addressing 'how' or 'why' questions, he also suggested that they may be utilised in exploratory research to address 'what' questions. The researcher's level of control over events and actions was the second criterion. The environment cannot be controlled in the same way that laboratory circumstances can be when examining the influence of a particular social policy, for example. Such scenarios necessitate a different strategy than those that use an experimental methodology, in which the effects of many variables and circumstances can frequently be 'controlled' out. The last criterion was how much of the study was focused on current events rather than historical ones. When there is no access to events or the study is on the 'dead' past, Yin argues that histories are the best option.

While Yin provided a broad description of what sorts of research a case study may be used for, he noted that researchers may be forced to choose between a case study and a survey. As a result, this chapter must explain why a case study technique was thought to be acceptable in this example. The three conditions outlined above will be referenced in this process. The research's main question is: *How has The Collaborative facilitated the integrated care process for mental health outcomes in one London Borough?*

This is certainly a 'how' question and, as previously stated, (Yin, 1989) would characterise it as being best answered using a case study technique if there has been minimal previous research on the subject. The dearth of existing research on integrated health and social care services in mental health services has been mentioned in previous chapters. Since there was little existing evidence which to rely upon and develop a more broad-based argument, it was decided early on that a study in an under-researched field like this should focus on a single geographical location. When nothing was known about whether the modifications had any specific mental health repercussions, it would be more suitable to investigate this in depth in one local authority. Case study approaches may be both affirming and challenging since they may uncover both conflicts and tensions. However, they may be empowering for the participants because they appreciate their experiences and demonstrate how their work contributes to service improvement within organisations (Payne et al., 2007).

4.4 Methods

After learning about case study methodology, the next thing to consider is: What methodologies should this research study use? As previously indicated, this will be determined by the project's aim, objectives, and the strategic means required for achieving them.

There are two primary schools of research methodologies employed in the social sciences: quantitative and qualitative, which can be combined to form the mixed methodological approach. Quantitative research is a type of empirical study that collects, analyses and presents data numerically rather than narratively (Donmoyer, 2001). This is in stark contrast to qualitative research approaches, which are best suited to answering ‘why’ or ‘how’ questions. These methods are commonly used to investigate a novel occurrence and to record a person's thoughts, feelings, or perceptions of a process (Given, 2008). Consideration of this duality yielded various suggestions as to the most suitable approach for conducting this study - qualitative methods. Qualitative research is concerned with explanation, theory formation, and the development of understanding at the ‘micro-level’, and is usually conducted within an interpretative or constructivist paradigm. A qualitative research approach can give insight into people's perceptions and experiences of health and sickness (Green and Britten, 1998), which is in line with the study's objectives.

Creswell et al. (2007, p.40) discuss *When to Use Qualitative Research* in detail, focusing on each of these difficulties separately. Each of their comments may be analysed in the light of this research study: qualitative research is conducted because we require a sophisticated, deep comprehension of the mental health issue. As previously stated, the methods I chose were determined by what I wanted to accomplish in conjunction with the research question and objectives. For data gathering, the current study uses triangulation: documentary policy analysis, semi-structured interviews, and focus groups.

4.4.1 Accessing the London borough

The researcher was the Chair of Health and Wellbeing board in a London borough prior to commencing the research. At the London Health and Wellbeing Board Chairs' Network meeting, the researcher met the Chair of the research borough's Health and Wellbeing board. Before commencing the research, the researcher had no prior affiliation with the research borough or its Chair of the Health and Wellbeing board. The researcher learned about the research borough's integration strategy and *The Collaborative*, which is more than ten years old, as a result of the quarterly network meetings. While awaiting ethical approval from the University Research Ethics Committee (UREC), the researcher engaged in additional discussions with the Chair of the Health and Wellbeing board of the research borough in an effort to establish connections with the teams so that data collection could commence as soon as ethical approval was granted. The researcher was aware that without this preceding induction, the duration of the study would be prolonged.

Due to the interpretive nature of qualitative research, it is essential that the researcher actively participate in gathering and analysing data. Knowledge about the cases and the people who will be contacted prior to data collection is significant. A good rapport between the researcher and the participants is essential to a successful study. It is crucial that the researcher is completely prepared and equipped to record any prospective data that can contribute to producing compelling findings before entering the research setting (Perecman and Curran, 2006).

The case study method involves a range of data collection tools in order to answer the research questions with maximum breadth. Collecting data from multiple sources allows triangulation (Yin, 2009), as employed by the current study. Gaining access to research settings is crucial and this is a common problem amongst researchers (Schatzman and Straus, 1973; Johnson, 1975; Shaffir, Stebbins, and Turowetz, 1980). This involves both securing entry into a particular organisation and ensuring that individuals associated with it, such as employees or users, will serve as informants, or in the particular case of this research, local policy documents, leadership team and the front line staff of *The Collaborative*. In qualitative research the person who introduces the researcher into the field is called the gatekeeper (Schwartzman, 1993:3-4). From the initial discussions with the Chair of Health and Wellbeing board, the researcher understood that the Assistant Director of Clinical Commissioning Group (CCG) of the London borough was the gatekeeper and could introduce the researcher to *The Collaborative*'s environment and organisational structure as seen in Figure 1.2 in section 1.3 of the Introduction chapter. The Chair of Health and Wellbeing board introduced the researcher to the gatekeeper and access was initially negotiated with the individual. Schwartzman

(1993:4) explains that the manner in which one presents oneself to gatekeepers in an organisation is vital for establishing particular expectations about one's study, as well as for getting access to a setting. In accordance with Schwatzman, the researcher organised the appropriate materials, including the research proposal, information sheets, advertisement for participants, draft questionnaires, and consent forms, which she could present for discussion at the initial meeting. The researcher also studied the research proposal well in order to answer any questions the gatekeeper might raise at the meeting, and she dressed appropriately, as she was aware of the significance of this initial meeting to the overall success of the research process.

The initial meeting with the gatekeeper progressed well as the gatekeeper outlined *The Collaborative*'s organisational structure, which is shown in Figure 1.2 in the Introduction chapter, section 1.3 and the researcher described the study design. Based on the information provided by the gatekeeper describing the organisational structure of *The Collaborative* within the London borough, the researcher identified key members of the leadership team and stakeholders. Even though the researcher learned about *The Collaborative*'s monthly breakfast meetings through the Chair of the Health and Wellbeing board, the gatekeeper confirmed access to these meetings and pledged to offer access to a variety of reports, statistics, and contact information for key stakeholders (Appendix 7). The researcher attended *The Collaborative*'s monthly breakfast meetings on the invitation of the gatekeeper after gaining ethical approval from the university. The gatekeeper introduced her to the leadership team and some frontline employees.

4.4.2 Triangulation

Methods of extending researchers' efforts ‘far beyond what is routinely done’ are referred to as triangulation (Flick, 2007, p.37). This procedure aims to provide in-depth information and improve research quality (Barbour, 2001; Yeasmin and Rahman, 2012). The goal of triangulating is to create a cluster of evidence that nurtures trustworthiness (Bowen, 2009).

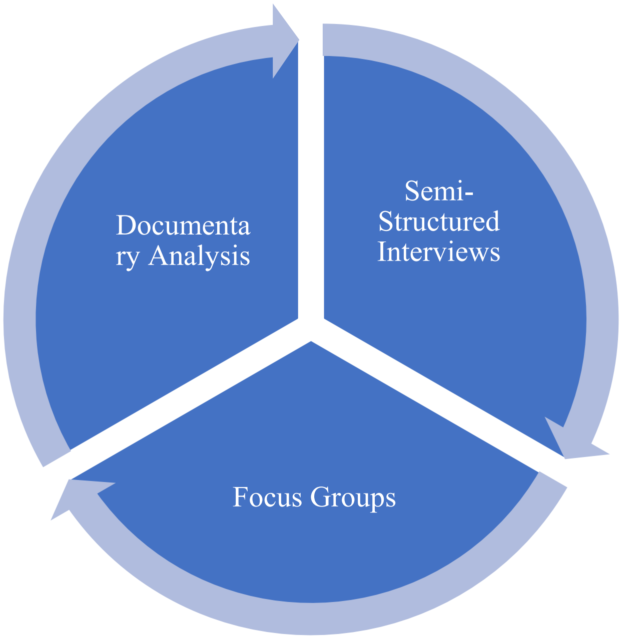
Figure 4.2 Methods of Triangulation

As shown in Figure 4.2, Denzin (1978) proposed four methods of triangulation:

1. Data triangulation (using data collected at different times, locations or with people)
2. Investigator triangulation (using several different researchers or analysts)
3. Theory triangulation (using multiple perspectives to interpret data)
4. Method triangulation (using multiple methods to study a single phenomenon)

To verify that the findings were of high quality, this study used data and method triangulation. This was achieved by combining data from policy and local documents, as well as semi-structured interviews and focus groups (Figure 4.3). The combination of these methods and the data gathered aimed to provide a richness and depth of knowledge about mental health practitioners' perspectives.

Figure 4.3 Stages of Data Collection



4.4.2.1 Stage 1: Documentary Analysis

Documentary analysis is a sort of qualitative research in which the researcher analyses materials to give them meaning and voice in connection to a research topic (Bowen, 2009). In the same manner that focus groups or interview transcripts are analysed, document analysis entails categorising material into themes (Bowen, 2009). Documents can also be graded or scored using a rubric. Documentary analysis is a research method used in social science, business studies and legislation. It is a significant research instrument in and of itself and is an essential component of most triangulation schemes (the use of many approaches to explore the same topic) (Bowen, 2009). Qualitative researchers frequently employ at least two resources, such as diverse data sources and methods, to seek convergence and confirmation. According to O'Leary (2014), there are three main sorts of documents:

- Public Records: An organisation's official, continuous records of its actions. Student transcripts, mission statements, yearly reports, policy manuals, student handbooks, strategy plans, and syllabi are all examples.

- Personal Documents: First-person narratives about a person's actions, experiences, and views. Calendars, e-mails, scrapbooks, blogs, facebook postings, duty logs, incident reports, reflections/journals, and newspapers are all examples.

- Physical Evidence: Physical objects found within the study setting (often called artefacts). Examples include flyers, posters, agendas, handbooks, and training materials.

The papers included in this study were public records, and they included local policy papers that were utilised to implement *The Collaborative*. Seven collaborative papers were analysed as part of the current study's document analysis method. Fairclough's (2013) critical discourse analysis was first favoured as an analytical method, based on Carabine's methodology to study relationships across policies and employing some of the close reading approaches and proposed excursions (Carabine, 2001). Instead, Braun and Clarke's (2006, 2013) approach to thematic analysis was used as an analytical tool. In the later stages of data collection, the researcher began coding the material (Appendix 9) with the matrix analysis (p. 91), and then with NVivo 11, identifying, refining, and linking the emerging themes through a process of classification and re-classification of codes at increasingly more analytical/conceptual levels. The researcher recorded a series of memos in NVivo

11 during data collection and analysis for herself about any questions, thoughts or worries that had developed during the study. Her constant reading had an impact on her analysis (Tuckett and Nikolic, 2015). Another phase in the document analysis was to characterise the background for the local documents and meeting minutes, as well as to see if local strategies and reports impacted collaborative organisations to act on mental health inequality.

4.4.2.1.1 Identifying Documents

The following factors were considered while choosing documents for the analysis: which organisations would be included, the sorts of documents to be analysed, and the dates of publication and distribution. For the first phase of qualitative document analysis, organisations had to be currently involved in *The Collaborative* project and have acceptable integration policy, strategy or guideline documents in the public domain.

Mental health documents from the council's Health and Wellbeing Board meetings, cabinet and council meetings, local mental health documents from *The Collaborative's* partners, and mental health documents with publication dates after 2010 were used as inclusion criteria. Dates of publication were evaluated so that the exercise may be used as a 'baseline' for tracking changes and improvements in policy and practice over time. This phase of health and social care policy integration focused on papers issued after 2010. This was because *The Collaborative* was founded in 2010 to bring about reform in the mental health system.

Conversations and debates at the monthly breakfast meetings organised by *The Collaborative* and from the leadership team of their partners were another means of identifying the local documents. The breakfast meeting minutes were also published in the local documents. By examining the local documents and discussions, seven collaborative documents (Table 4.1) that satisfied the inclusion criteria were identified.

Table 4.1 Policy Documents

The Collaborative Documents (Names anonymised)
Joint working between Council and NHS
Establishing a Health and Wellbeing board for the London borough
Transforming Adult Mental Health Services and Support – The Collaborative

Integrated Alliance – Adult Mental Health
Confederation Proposal
Together Integrating and Transition Programme
Service User not System

4.4.2.2 Stage 2: Semi-structured Interviews

The goal of the semi-structured interview was to give each individual the opportunity to express and articulate his or her beliefs and ideas about *The Collaborative*, as well as to focus on the three themes developed during the policy data analysis: parity of esteem, socio-economic factors, and deprived communities. The interview aimed to allow each participant to transmit his or her perceptions and notions of the integration of health and social care in mental health and to enable the voice and the narrative to emerge. According to the idea of social constructionism, the basic premise of each interview was that each participant views reality differently, and that each participant will create and make sense of the world by using language and idioms, for example, to transmit meaning. This common knowledge is socially embedded, as well as socially developed (Hogg, 2001).

There were several reasons why interviews were the best option for this study. Easy to organise, minimum resources (Denscombe, 2010), and the flexibility to prioritise subjects were all practical considerations (Gillham, 2010). Interviews aid knowledge generation and unveil entities that the researcher may not have considered (Herzog, 2005). This is critical since the study's goal was to not just understand what was going on in *The Collaborative* in terms of results, but also to explore why it existed and what it meant. Even though semi-structured interviews are beneficial, there are limitations when employing them. Making broad generalisations is difficult and time-consuming, and the practice has been criticised as an artificial construct that creates a false sense of security (Denscombe, 2010; Hoffmann, 2007). However, the study aimed to gain in-depth detail of the directors and the leaderships' views. Consequently, complete generalisability was impossible. During the access period, a report was created with *The Collaborative* through attending their monthly breakfast meetings, as well as associated events and social gatherings. As interviews are personalised and might constitute an invasion of privacy, this meant that trust needed to be formed so that the respondents were at ease during the data collection (Esterberg, 2002; Denscombe, 2010; Silverman, 2011).

Active interviews, in which the researcher acts as a 'traveller' (Kvale, 1996) asking questions that allow participants to relate their stories, would aid in the development of a thorough knowledge of health and social care integration and mental health. Semi-structured interviews were acceptable to my paradigmatic assumptions, despite their snapshot character and potential for conscious, unconscious and recollection bias.

4.4.2.2.1 Semi-structured Interview Participant Recruitment

There are two basic forms of sampling in research: probability sampling, which includes a random selection of individuals, and non-probability sampling, which does not. Non-probability sampling, according to Denscombe (2010, p.25), is employed when researchers find it impossible or undesirable to determine their sample by random. Purposive sampling, according to (LoBiondo-Wood and Haber, 2014), is suitable for collecting exploratory data or data from a very specialised population.

To ensure the research questions were answerable, the study required a sampling strategy that would enable access to respondents who could contribute information about *The Collaborative* and its impact on the mental health and wellbeing of people (Patton, 2002). Purposive sampling was used in this study since the participants possessed specialised mental health knowledge, practice, and experience. The idea was to obtain access to those who were directly involved in *The Collaborative* yet played different roles within it. It was also decided to use a feasible sample given the existing resources, practicality and time constraints (O'Leary, 2014). Furthermore, because the philosophical and methodological methods required rich data important to the study, a purposive sampling technique was judged acceptable (Denzin and Lincoln, 2018).

The inclusion criteria were the directors of the alliance leadership team, alliance management team and *The Collaborative* directors who had been active for at least three years. Three years of experience for the directors was chosen as a benchmark because a three-year evaluation programme was funded by a charity to assess the collaborative hub's impact and develop the economic rationale of community-based mental health care. The researcher had no direct experience of working in the mental health team. Once the inclusion criteria were drawn up, measures were put in place to ensure participants across all the partnership organisations were sought (Appendix 6) through the gatekeeper, who was the Assistant Director of CCG in the local authority where the study was conducted. A permission letter was received from the gatekeeper (Appendix 7) to access various reports, data, contact with key stakeholders and to attend relevant meetings. As the researcher had been attending the monthly meetings organised by *The Collaborative* soon after receiving ethical approval from the University, she already knew some of the participants.

The researcher conducted semi-structured recorded interviews with the directors and the leadership of the alliance leadership team and the alliance management team, including the council, NHS, CCG, collaborative commission and the local charities. An email invitation for the semi-structured interviews (Appendix 3) was sent to the participants, along with the participant information sheet for interviews (Appendix 1) and an interview guide (Appendix 4), asking them to respond directly to the researcher. The sample semi-structured interview questions included the policy and practice on integrated care and mental health provision prior to starting *The Collaborative* and its impact. In addition, the barriers and facilitators in achieving the collaborative outcomes and *The Collaborative*'s impact on the culture and ways of working of staff were also included in the interview guide. Once the researcher received the responses, a telephone call was organised with the participants to explain the process and to organise the date and time of their interview, if they agreed.

It was also crucial to evaluate the length of the interview, considering the participants' strenuous work schedules. According to (Robson, 2001), an interview lasting less than half an hour is likely to be of little value, while anything more than an hour may be excessive for busy interviewers. With this in mind, the duration of the semi-structured interviews in this study was restricted to 45 to 60 minutes. When I asked a member of staff to be interviewed, their first question was usually, 'How long does it take?' And when I told them it would be under an hour, they all appeared relieved, which gave me confidence in my decision to keep the interview short. This is crucial for both the interviewer and the interviewee since a protracted interview might detract from the quality and usefulness of the process.

The research took the form of 13 in-depth semi-structured interviews to elicit the directors and the leadership team's views. The format of the interviews consisted of a set of openers, open-ended questions, and subsequent discussion of *The Collaborative*, where I invited each participant to express their opinions and their beliefs about the impact so far and the future of integrated working in mental health in their organisations. I then began to use the responses to explore beliefs using techniques such as probing and clarifying. At the end of each semi-structured interview, the interviewees were asked to sign a participant consent form (Appendix 2) and they were given a copy to keep.

My role as a researcher was that of both investigator and observer. I placed myself in a situation where I was able to listen, observe and occasionally prompt each participant. I drew from the principle of *verstehen* (Hewa and Herva, 1988). *Verstehen* reflects the notion of 'empathic understanding' and, thus, an appreciation of each subject's reality. ‘Truth’ as a concept is not sought, rather it is how each individual experiences the world that is most important, and the fact that perceptions are contextually, historically and socially determined. The interviews took approximately 12 months to arrange, undertake and analyse. Thirteen interviews were conducted within six months, with one still at the analysis stage due to the availability of the interviewee.

4.4.2.3 Stage 3: Focus Groups

The use of focus groups in this research had two goals: to share stories with others to highlight what was working in the research context, and to allow the group to see areas of commonality and differences in their stories. The focus group method was also particularly useful in illustrating the social construction of the topic (Wilkinson, 1998; Morgan, 2012), allowing people to interpret their own experiences in the light of listening to others (Stahl, Tremblay and Lerouge, 2011). An additional advantage of focus groups is that they can supplement and enrich findings (Morgan and Krueger, 1998) and illuminate multiple (and potentially contrary) perspectives and layers of discourse (Schattner, Shmerling and Murphy, 1993; Patton, 2002). ‘*A focus group discussion is commonly used as a method of qualitative research in the sociology of health and illness’* (Lawton and Parker, 1999, p. 353).

Crabtree and Miller (1999) note that the choice of whether to use homogeneous or heterogeneous focus groups should be influenced by the research question. Consequently, in this research, the focus groups were heterogeneous to reflect the research epistemology and ontology, to respond to the gap in the literature identified in Chapter 3 and, subsequently, to align with the research aim. In this research, the heterogeneous focus groups included front-line staff with a mixture of responsibilities.

Calder (1977) advises that this method is particularly useful in producing rich data, while Crabtree and Miller (1999) describe the benefit of heterogeneous focus groups as bringing together diverse experiences. Heterogeneous focus groups also provide a means of enhancing mutual understanding and discovering shared interests (Bauer et al., 2010). Crabtree and Miller (1999) identify that these may incur a risk of a power imbalance or lack of respect, while Carey and Smith (1994) believe that homogeneous groups are more likely to positively influence interaction.

When considering the research objective - namely to explore the views and experiences of the staff working within *The Collaborative* on the initiative’s impact on the mental health of the population and to provide policy and practice improvement recommendations for integrated mental health provisions - a focus group was one of the logical and effective approaches to gather the perceptions of the operational staff of *The Collaborative* in this research. This meant that data could be acquired from the participants' interactions. Because the interaction occurs between participants, the moderator has less control, allowing for the predominance of participants' ideas and unforeseen concerns to develop (Kitzinger, 1995). As a result, focus groups aid in the capture of notions with varying levels of unanimity and divergence as group discussions might be challenged or validated by others (Gibbs, 1997; Kitzinger, 1995; Webb and Kevern, 2001).

In this research, steps were taken to minimise drawbacks and risks by being responsive and sensitive to the emotional climate of the group, possible through having closely worked with the service users. I was familiar with facilitating heterogeneous groups through my prior experiences as a Councillor. In addition, I have also facilitated a focus group on ageing and loss attitudes at the University of Greenwich for one of my supervisors. At the start of each focus group, we would take time to explore how we wanted to work together and reflect on what was important to us (examples included: that people did not have to speak; that we should try not to talk over one another; that participants could leave if they wanted to). At the start of each meeting, I reiterated that we were all there because we had an interest in the topic. I then took time to revisit consent and clarify that the participants were happy that the groups were being audio-recorded.

4.4.2.3.1 Focus Group Participant Recruitment

The employees of *The Collaborative* included the statutory sector staff, such as health professionals, occupational therapists, social workers, and mental health nurses; voluntary sector staff, such as support workers, and people with lived experience. A variety of new ways of working had been discovered over the years, including support to find work or get back into education, peer support, sanctuary, and several more. Community discussions had also been organised to collect ideas for making the services better. A total of five focus groups were conducted. Inclusion comprised professionals and front-line staff of the four services of *The Collaborative*, which provided information on mental health services in the borough. This study used purposive sampling because the focus group participants were from services such as integrated alliance, collaborative centres, collaborative house and peer support networks. Most of the participants of the focus groups attend the monthly meetings of *The Collaborative*. To recruit the participants, the researcher presented the abstract, aim and objectives of the study at one monthly meeting. The researcher identified the gatekeepers in each of the four services through the research gatekeeper. This enabled the researcher to communicate with the focus group participants.

Prior to the COVID-19 pandemic, an email invitation to join the focus groups (Appendix 3) was sent to the above participants, along with the participant information sheet for focus groups (Appendix 1) and the focus group guide (Appendix 5), asking the participant to respond directly to the researcher. The location of the focus group meetings was planned to be at the four centres, where the programmes were running.

Two focus groups were scheduled during March 2020 with the collaborative centres and the integrated alliance. Unfortunately, the collaborative centres meeting was cancelled due to the pandemic and future ones were put on hold for the same reason. The integrated alliance focus group continued as scheduled and at the end of the meeting, the participants were asked to sign a participant consent form (Appendix 2) and they were given a copy to keep. Having spoken to my supervisors and followed their advice, I contacted the services to conduct a pilot study for an online focus group using the University of Greenwich authorised technology, Microsoft Teams. The piloted focus group session was recorded using Microsoft Teams and was password protected. During the pilot focus group, the first supervisor joined the session as an observer to confirm that there were no online distractions while the meeting was taking place.

The pilot focus group was successful and, on reflection after the meeting, the supervisor confirmed the same. I was able to facilitate the session effectively so as to capture the thoughts and experiences of the participants. As the pilot focus group was successful, the University Research Ethics Committee (UREC) was contacted to make amendments so that I could conduct the remaining two focus group meetings online using Microsoft Teams. After receiving UREC approval (Appendix 13), the gatekeepers were contacted to organise the next meetings.

An e mail invitation (Appendix 12) was sent to the focus group participants, along with the participant information sheet for online focus groups (Appendix 10) and the focus group guide (Appendix 5), asking the participants to respond directly to the researcher. The online participant consent form (Appendix 11) explained that the focus group would be conducted and recorded online using Microsoft Teams and a transcript would be made available. The focus group discussion included the steps taken to achieve the collaborative outcomes, in particular the processes undertaken to facilitate mental health outcomes for the population. In addition, the barriers to and facilitators for their organisation and the staff members in doing their job effectively and the tools and techniques used to promote sustainable change were also discussed. After conducting the four focus groups, the first supervisor brought the concern of not having the statutory sector front line staff among the focus group participants. The gatekeeper was contacted once again to organise a fifth focus group online with the statutory sector front line staff only. All four online focus groups were attended by at least one of the supervisors as an observer. The sample size of the focus groups was four and the duration was for one hour.

4.4.2.4 Decision about Service User Participation

It had initially been the intention to collect data from the service users through semi structured interviews or focus groups, as the research from the perspective of service users has the potential to, at the very least supplement, and at most transform our understanding of mental health (Faulkner and Thompson, 2021). According to Faulkner (2017), the need for service user involvement is clear: those with lived experience can give us insight into the subjective experience of distress, diagnosis, use of services, battles with discrimination, coping mechanisms, and what 'recovery' looks like.

However, the three-year evaluation of The Collaborative Hub in the research borough by a charity collected experiences of service users and carers via PPI (patient and public involvement). At the beginning of the study, I came to recognise that the year one evaluation adopted four methods with the service users. This included client satisfaction questionnaire, which received 101 responses, a face to face survey with 39 interviews, collecting stories from five people who have been supported by the Hub, a voice in ongoing service development, by providing user-created knowledge and insights which give the Hub as an organisation material to reflect upon so as to develop and improve their practice. The fourth method was Work and Social Adjustment Scale (WASAS) sample, which is a measure asking people to rate their impairment using 5 areas, ie. Home management, ability to work, social leisure activities, private leisure activities and close relationships. The year one evaluation has collected 136 WASAS sample and the year one evaluation report was produced. As a consequence, I had a discussion with the supervisors on service user involvement. On supervisors advice, it was decided to conduct the three stages of the study and use the three evaluation reports of The Collaborative Hub from 2015 to 2018 for service user involvement. In the second year, the structured interviews collected data concerning sociodemographic and clinical variables from 38 people who had been supported by the Hub, as well as on other service use, amount of contact with the Hub, what problems were presented, how these were addressed and what the outcomes were, service satisfaction, and suggestions for how the Hub's service could be improved. In addition, there were 139 completed client satisfaction questionnaires, 14 stories and 150 WASAS samples. During the second year evaluation, The Talking Shop was setup. It is referenced under 6.2.1.2 Peer Support and it is a weekly discussion session for a group of invited people who have been receiving Hub support. In addition to the four methods in the evaluation report, the second year evaluation report includes the feedback on The Talking Shop. The third year evaluation included 8 stories from service users, 84 client satisfaction questionnaires, 61 WASAS samples and 69 responses to the telephone survey. The three year evaluation reports from 2015 to 2018 were analysed and connected with the findings of this study under Discussion chapter.

4.4.3 Pilot Study

To examine the effectiveness of the interview and focus group questions concerning the research topics, a pilot study was conducted. In pilot studies, you utilise 'modes of operation' and 'processes' on a bigger scale to test the techniques and procedures that you want to utilise on such a scale. According to Samet et al. (2009), the primary objective of pilot research is to discover whether a certain strategy can be implemented in a more extensive investigation. In this research, the interview guides were prepared at an early stage to meet the requirements of the UREC, to derive answers to the research questions through the methods, and to address the research aims. Once the interview guides were approved by the UREC, the focus was on piloting them. Piloting the interview guide for the directors and the leaders of *The Collaborative* was done with the support of two directors of another integration initiative in a different London borough. The same procedure was followed for the focus group guide with front-line staff and the professionals of an integrated care system in a London borough with similar demographics as the borough where this study was conducted.

Although the interviewees did not have any direct experience of mental health provisions, some of the suggestions enabled them to make some changes to the interview guide on governance and measuring outcomes. The initial interview guide was mainly concerned with measuring outcomes against the collaborative outcomes, the same as was used in the research borough. After the two pilot studies, the interview guide was adjusted to include quality improvement targets and matrices for measuring the success by asking questions such as:

What are your metrics for measuring the outcomes? Do you have quality improvement targets? How have you planned or what is the plan to achieve them?

Please tell us about the partnership model that you have implemented, the type of agreement you have, your governance, and any risk or gain share, pooling of budgets agreements. What are the key benefits of these?

The additional questions explored how the integrated care system operated. The two pilot interviews allowed me an advanced option to address certain difficulties with the team's structure while also assisting me in refining my questioning technique. A pilot study was also conducted for a focus group due to COVID-19 restrictions.

4.5 Data Analysis

4.5.1 Thematic Analysis

A thematic analysis was performed on the data from the documents, interviews and focus groups. Such an analysis is '*a process for detecting, analysing, and reporting patterns (themes) within data*', according to its definition (Braun and Clarke, 2006: p.79). The thematic analysis was carried out using the principles outlined by Creswell (2009), Howitt and Cramer (2011), and Braun and Clarke (2006), who stated that while thematic analysis is widely used and cited as a method of qualitative data analysis, little attention has been paid to how it should be carried out. As thematic analysis is not linked with any one theory or technique, and because of its flexibility, it may be utilised in a variety of theoretical frameworks (Howitt and Cramer, 2011; Braun and Clarke, 2006), and it was the best method for analysing the qualitative data.

Inductive and deductive approaches were used to develop themes from the data (Howitt and Cramer, 2011; Braun and Clarke, 2006). The former is connected with themes intimately tied to the data, having little relevance to the research questions, nor guided by the study area/topic, with no pre-existing coding frame developed, the codes arising entirely from the data itself, and the strategy being data-driven. While a deductive method is theory-driven, tending to result in richer descriptions since it is based on the researcher's theoretical or analytical interests, as defined by Braun and Clarke (2006).

The evolution of themes was suggested by Braun and Clarke (2006) and Howitt and Cramer (2011) in six clearly defined phases; these phases were used for the thematic analysis as follows:

1. Familiarisation – I transcribed the data to obtain a feeling of the overall picture. As I began to make some interpretations, I began to take notes (or memos).
2. Creating and listing the initial codes, then applying them to the entire data set, allowing for ideas to emerge as to what was happening in the data.
3. Finding the themes – by reducing the number of categories and compressing the coding in a logical way.
4. Reviewing the themes – analysing the data to determine whether the themes worked with the coded extracts and, subsequently, with the entire data set.
5. Defining and renaming the themes - understanding how one theme differs from another and coming up with precise descriptions for each one.
6. Writing up – commenting on the facts and illustrating the interpretations given to the themes using excerpts (this will be presented in the findings chapters).

4.5.1.1 Documentary Analysis

Thematic analysis is an effective way of analysing documentary evidence, especially as a means of giving context and background information (Bowen, 2009; Coffey, 2014). Documentary analysis (Bowen, 2009; Prior, 2003, 2008; Vaismoradi et al., 2016), which includes qualitative content analysis and theme analysis (Bowen, 2009; Prior, 2003, 2008; Vaismoradi et al., 2016), was conducted on a subset of the papers indicated in Table 4.1 above. The thematic analysis was used to examine the documents.

'People who produce papers are likely to have a certain point of view that they wish to get across,' writes (Bryman, 2008, p. 551). The researcher tried to remember that documents, rather than just expressing organisational reality, are a different level of 'reality' in and of themselves, having importance in terms of their intended audience and the goals for which they were created (Atkinson and Coffey, 2011; Bryman, 2008; Prior, 2003, 2008). Documents may only provide a partial or superficial account of what they describe due to their low level of information. For instance, policy papers may reflect ambitions rather than reality (Shaw, Elston and Abbott, 2004). They are also intended to address issues and offer (explicit or implicit) remedies to those issues, which must be recognised and analysed (Bacchi, 2009) cited by (Hammond and McDermott, n.d.). As a result, the researcher wanted to look at the semantic information from both a latent and manifest perspective.

4.5.1.1.1 Analysis Matrix for Documentary Analysis

Drawing on Jupp and Norris (1993), the following matrix was used to analyse the documents in this study.

- What social issues does this policy tackle?
- What principles underpin this policy?
- What are the policy intentions?
- Can you separate the administrative arrangements from their intentions?
- Identify the administrative arrangements.
- How is power allocated through this policy? To whom? How? Why? At what expense?
- What are the policy outcomes (real or desired)? Compare and contrast with policy intentions.

A total of seven documents (Table 4.1) were analysed using this matrix as shown in Appendix 9.

4.5.1.2 Process

The 13 interviews took place over the course of six months, from April to September 2019. The five focus groups were held over the course of nine months. Due to the processes required to obtain ethical permission for the online focus groups and to recruit participants, the COVID-19 pandemic caused the focus group meetings took longer to complete than anticipated. The interviews were transcribed into written form (word processed) as they were conducted, allowing familiarisation with the material as it was gathered. I would write memoranda and ask questions while I transcribed, reflecting on what I was learning from the participants. According to Braun and Clarke (2006), the early ideas reflected the fact that transcribing interviews is a critical step in data analysis, recognised as an interpretative act, in which the researcher actively attempts to make sense of and generate meanings from the data. The transcripts were reviewed several times once all of the transcribing was finished, allowing me to thoroughly immerse myself in the facts.

NVivo 11 was used to store and analyse the data. Audio.mp3 files were transcribed into Word, then transmitted to NVivo and analysed as soon as was feasible after the introduction of NVivo. Using NVivo was comparable to conducting research by hand, except that instead of cutting and pasting connected categories of data together, NVivo allows for electronic 'tagging' of data into categories or 'nodes.' This marking also makes the process of comparing nodes easier. In an iterative procedure, analysis began as soon as the first data were obtained and continued throughout the semi-structured interviews and focus group phases (Corbin and Strauss, 2008). All the raw data were imported into NVivo after I had transcribed the interviews and the focus group data myself. All the papers were reviewed at least three times before being coded into nodes using NVivo's tools. I took into account not just 'what' the participants had said, but also 'how' they had expressed it (Silverman, 2011), aspects which I had captured in my handwritten notes. While coding, I evaluated not only the participants' spoken language when discussing particular topics, but also their body language and tone of voice.

After all the sources had been coded, I went over them all again in a refining process. Then, I started making connections and comparisons between nodes. The links between distinct categories were investigated when the nodes were transformed into high-level themes. Data were categorised according to differences and similarities, and links and patterns in the data were studied using a continual comparison approach (Corbin and Strauss, 2008). In focus groups, for example, ‘communication’ began as a separate node from ‘differences in staff culture’, but when the two nodes were compared, it was clear that communication was part of a larger theme of staff culture since much of the data for both nodes were comparable. One of the key advantages of using NVivo was the ability to simply construct linkages between nodes, and I was able to clearly understand interconnections between them on screen since I could examine all of the data I had allocated to each node. Throughout the analysis, electronic and paper memoranda were made. Memos were also used to keep track of notes from the semi-structured interviews and focus groups.

4.6 Establishing Quality

Measures were taken in this study to assure the findings' reliability and dependability, which continues to be a difficult problem in qualitative research; standards have been developed to address this (Elliott, Fischer and Rennie, 1999; Flick, 2007). These criteria were not meant to be comprehensive; rather, they were to be used in combination with the epistemological perspective and the approach that I have selected (Barbour, 2001). The most often used approaches to increase quality in qualitative research were evaluated in this study, and some of them were employed, such as thick and rich description, triangulation, member checking and researcher reflexivity (Carlson, 2014; Elliott, Fischer and Rennie, 1999; Flick, 2007).

4.7 Reflexivity

Reflexivity is highly promoted in qualitative research (Haynes, 2012) since it improves rigour and trustworthiness while also revealing any subjective impact on the research findings. Furthermore, as a Councillor and the founder of a mental health charity, I have been continually urged to participate in self-awareness and critical thinking. These exercises have improved my capacity to recognise and cope with my own prejudices, strong sentiments, unease, and looming obstacles.

I have always been conscious that this study was inextricably linked to my time working for a mental health charity, my identity, my casework experiences, my worldview, and my professional viewpoint on what it means to be the Chair of the Health and Wellbeing Board. I realised that my viewpoint would have an impact on how I engaged with the study and, as a result, how I interpreted it (Ritchie and Lewis, 2003). As a result, I needed to be reflective during the research process. This type of reflexivity can also assist readers in making their own conclusions about how the researcher may have affected the research (Kasket, 2012). Throughout the study process, I realised the need to reflect on my thinking, ideas, beliefs, feelings, assumptions, and behaviour on a regular basis (Cunliffe, 2009). As a result, during the study process, I kept a reflective notebook. Throughout the research process, I kept track of what I did, when I did it, and why I did it to establish my involvement in the study and any potential effect I could have had on the outcome (Ratner, 2008). I found myself being both objective and subjective in my thinking as both an insider and an outsider to this study, which affected it both favourably and adversely. This will be covered in the thesis' concluding chapter.

4.8 Ethical Considerations

According to Greig, Taylor and MacKay (2011: p. 169), '*ethics is the one aspect of the research process that should never be taught in practice*,' and '*the would-be researcher should have guaranteed that all potential ethical difficulties have been explored before beginning on the research*.' Although conceding that one can never entirely anticipate what might occur during the process of doing research with human beings, this was a philosophy that I chose to adopt (Guillemin and Gillam, 2004; Holloway and Jefferson, 2012).

'*In every study, it is critical for the researcher to safeguard the participants from harm and danger, while still respecting their rights*' (Bowling, 2002: p. 158). The researcher guarantees, according to Couchman and Dawson (1995) cited by (Holloway, 1997: p. 55), that their subjects will not be harmed, their involvement based on information and an understanding of the research. The subjects' involvement is voluntary and their identity must be kept confidential and anonymised. '*Consider every study from the position of study participants, with the goal of reducing any hazards to psychological wellbeing, physical health, personal values, or dignity*,' according to the British Psychological Society's (2009) Code of Ethics and Conduct (2009: p. 19). Butler (2002) emphasised the need of doing so in accordance with social work values. All aspects of social work research and practice should empower and increase access to social and economic capital for the service users. This applies to methodology selection as well as the application of any findings, being consistent with the goals and values of social work practice. According to Mishna, Antle and Regehr (2004), there are three basic concepts that drive ethically competent research. Caring for the participants and giving them agency in their study is an essential component of doing research. Beneficence and non-maleficence should guide the study. Justice is another important ethical principle that should underpin the research. To follow these principles and conduct ethical research, the researcher must ensure that appropriate measures are taken in terms of selecting the participants, and that informed consent is sought from them. Additionally, to mitigate the damage and hardship, on balance, procedures should be in place to make sure the research does not cause a disparity between the researcher and the participants (Mishna, Antle and Regehr, 2004). As a result, I spent a significant amount of time planning the study to ensure that issues such as access, informed consent, anonymity, and confidentiality were considered, as well as, to the extent possible, potential ethical issues that might have arisen were anticipated, such as disclosure of poor practice or the researchers' potential impact on participants and vice versa.

Researchers may confront several hurdles while doing qualitative research, according to a growing body of data (Birch and Miller, 2012; Liamputtong and Ezzy, 2005; Braun and Clarke, 2013). The participants must be protected, boundaries must be maintained, reflexivity must be maintained, the filing must be maintained, and the least possibility of danger must be ensured (Liamputtong and Ezzy, 2005). While many of these challenges are specific to qualitative research, they are frequently exacerbated when investigating sensitive or challenging subjects (Dickson-Swift et al., 2007).

In this way, research ethics are critical to guarantee that both participants and researchers are safeguarded, as needed (Braun and Clarke, 2013). Before the start of this project, ethical permission was gained by following the standards specified by the University of Greenwich's School of Education, Environment and Development (Appendix 8). Informed consent and information sheet forms addressed ethical problems raised during the interviews (Appendices 1, 2, 10 and 11). These documents emphasised the participants' right to withdraw from the study at any moment, as well as what would be researched, to provide all participants with a better understanding of the nature of their participation. No force or undue influence could be used to get study subjects to participate. Participants were asked to sign a permission form (Appendix 2) once they had fully comprehended the study's specifics, including its possible risks and benefits (Smith and Fogarty, 2015). This was to confirm that they had fully comprehended the research and their commitment to it. The participants in the online focus groups were asked to complete an online permission form (Appendix 11) and send it by email. In the case of a participant being unable to return a signed online consent form, UREC certified that keeping the email from the participant who returned the form as proof was permissible. The anonymity of the research participants was prioritised, with pseudonyms used throughout the study to protect their identities. The information was encrypted, anonymised, and securely stored.

Participants were also reminded that their anonymity would be protected. In accordance with the university's data-collecting protocols, the audio recordings of the interviews were transcribed and encrypted. The transcribing was completed on my personal computer in a secure location in my house. The audio recordings and data were maintained in a closed container so that no one else could access them (Flick, 2016), and when they were transcribed, they were deleted. Anonymity was further ensured by keeping any contact information or identifying information separate from the transcripts, allowing only me to identify them (Flick, 2016).

4.9 Chapter Summary

This chapter provides an overview of the various methods used to collect the data that will be presented in the succeeding sections. It offers an in-depth analysis of how various methodological decisions were made, the influences of practical variables like accessibility and sampling, ethical concerns, and ideas about my position as a researcher and my identity on the data I collected. The research was conducted using a qualitative inductive technique based on the social constructionism paradigm. According to Jokinen, Juhila and Tarja (1999), social constructionism is an important and useful framework for investigating social work (such as that of *The Collaborative*'s mental health directors); it is an activity that helps to create reality and emphasises how any reality is defined, both through and in action. Inductive reasoning is prominent in this exploratory investigation. Qualitative research is concerned with explanation, theory formation, and developing understandings at the ‘micro-level’, and is usually conducted within an interpretative or constructionist paradigm. A qualitative research style can help researchers comprehend people's perceptions of health and sickness (Green and Britten, 1998), which is appropriate for this study. To guarantee that the findings were of high quality, this study used data and methodological triangulation. By combining data from policy and local documents, as well as semi-structured interviews and focus groups, method triangulation was used. The combination of these methodologies and the data gathered aims to provide a richness and depth of information about mental health practitioners' perspectives.

CHAPTER 5: DOCUMENTARY ANALYSIS FINDINGS

5.1 Introduction

In the United Kingdom, policies to promote the integration of health and social care have a long history. Successive administrations have attempted to bridge the barrier between health and social care, from supporting community care policy in the 1980s to promoting people's independence in the 1990s to care trusts to commission and be responsible for health and social care services in the 2000s (Houses of Parliament, 2016). The health and social care systems of the four UK nations are funded and operated in different ways; nevertheless, they all provide free healthcare at the point of entry and have committed themselves to better integrated care. New models for different forms of integration customised to local requirements were included in NHS England's Five Year Forward View in 2014 (NHS England, 2014). The pledge to further integrate health and social care was announced in the 2015 Spending Review. It said that by 2017, every part of the country must have an integration plan in place, which must be executed by 2020, with local communities employing different methods. Devolution of power to local governments was expected to result in innovative approaches to health and social care integration. In April 2016, the Greater Manchester Combined Authority (GMCA) received full control of its £6 billion health and social care budget (Greater Manchester Combined Authority, 2016) and released 'Taking Charge of Our Health and Social Care in Greater Manchester'.

Mental health services have undergone a profound transition over the last 30 years, and have gone further than any other sector of the health system in providing multidisciplinary, community-based alternatives to hospitalisation in many areas. Understanding which regulatory frameworks, or policy levers, are likely to succeed or fail, and why, is necessary for the establishment of an empirical base for mental health change. Although the apparent relevance of this endeavour is hampered by the difficulties of policy research, evaluations of prior endeavours might guide future policy creation (McConnell, 2010). The purpose of this chapter is to report the findings of the local policy analysis to answer the research question: *How has The Collaborative facilitated the integrated care process for mental health outcomes in one London Borough?* As noted in Chapter 4 Table 4.1, seven collaborative-related policies have been included in the study. These are presented in Table 5.1 below, based on interactions with collaborative leaders and local documents linked to the initiative.

Table 5.1 ***The Collaborative*** **Documents**

Name	Purpose	Author	Target Audience/Themes	Dates updated/created
1. Joint working between Council and NHS	Integrated working delivered through integrated staff management and aligned budgets with a single director, which will deliver more effective and efficient outcomes for the health, care and well-being of the borough's citizens.	Council	Current staff, general public Tags: Integration, council, NHS, commissioning, service user	July 2010
2. Establishing a Health and Wellbeing board for the London borough	The Department of Health has issued guidance which further strengthen the borough partnerships to improve health and wellbeing and to reduce the associated inequalities.	Council	Current staff, general public Tags: Partnership, improved outcomes, reductions in inequalities, population, NHS, adult social care, integration	April 2011
3. Transforming Adult Mental Health Services and Support – The Collaborative	Service transformation work, driven by *The Collaborative*, including public health and commissioners from across the whole system in relation to working age adults	Council	Current staff, general public and service user Tags: Partnership, population, NHS, health, integration, adult mental	October 2014

Name	Purpose	Author	Target Audience/Themes	Dates updated/created
	with severe and enduring mental health problems.		health, voluntary and community sector (VCS)	
4. Integrated Alliance – Adult Mental Health	Council enters into a Section 75 Partnership Agreement with NHS to pool commissioning budgets for Mental Health Rehabilitation Services and enter into an Alliance Agreement with providers. A 23 percent savings was offered to the CCG and council against the annual budget.	Council	Current staff Tags: Collaboration, partnership, service user, citizen, NHS, adult social care, integration, adult mental health, transformation.	February 2015 / March 2018 (Created:June 2012)
5. Confederation Proposal	Establish a confederation which is responsible for completely transforming the way that adult mental health services are delivered in the borough and embedding these changes across the entire system. This forms part of the	NHS	Current staff, general public and service user Tags: Collaboration, co-production, adult mental health, transformation, health, NHS, social care.	March 2017

Name	Purpose	Author	Target Audience/Themes	Dates updated/created
	wider Sustainability and Transformation Plan (STP).			
6. Together Integrating and Transition Programme	Proposal to establish ' Together Transition Programme' to integrate Health and Care in the research borough.	NHS	Current staff across *The Collaborative* Tags: Integration, co-production, adult mental health, transformation, health, NHS, social care, service user, outcomes.	October 2017
7. Service User not System	The work of the Integrated Alliance in the research borough, cutting down on inpatient rehabilitation bed-based provision by moving people with long-term mental health issues from institutional settings into specially created independent, community-based supported living accommodation.	NHS	Current staff, general public and service user Tags: Collaboration, co-production, long term mental health, voluntary and community sector, NHS, social care, service user, outcomes.	May 2018

The documents were analysed using the analysis matrix in Chapter 4 to find the common terms, their meanings and their purposes. Thematic analysis following the approach of Braun and Clarke (2006, 2013) was adopted as an analytical method and it is described in detail in Chapter 4, in the Data Analysis section.

5.2 Policy Analysis Findings

According to (Apple (1985) and Wexler (1987), through a broader analysis of social impacts on the people (leadership team) at the forefront of the implementation of many of these policies in the local authorities or at the organisational level, it is important to understand the perspectives, implementation tools and truths that are selected, framed and made available to society by those in government who, seemingly, have all the power. It seems, on analysis of the local documents listed above, that the three different governments (Labour, Coalition and Conservative) between the 1980s and the present have held similar motivations that have driven policy formation for integrated health and social care services (Shaw, Rosen and Rumbold, 2011) and mental health. The common drivers for the integrated mental health policies across the 30 years have included, financial pressures (Ling et al., 2012); communication and information-sharing across agencies (Erens et al., 2017); shared vision and leadership (Ling et al., 2012); organisational culture and professional boundaries (Ling et al., 2012); the workforce (Erens et al., 2017), and a place-based approach (Carter, Lewis and Ward, 2011). These drivers align with the policy intentions and policy outcomes of the analysed local documents in Table 5.1. According to the local documents, starting from 2010 to 2018, similar drivers have encouraged the research borough to introduce *The Collaborative*.

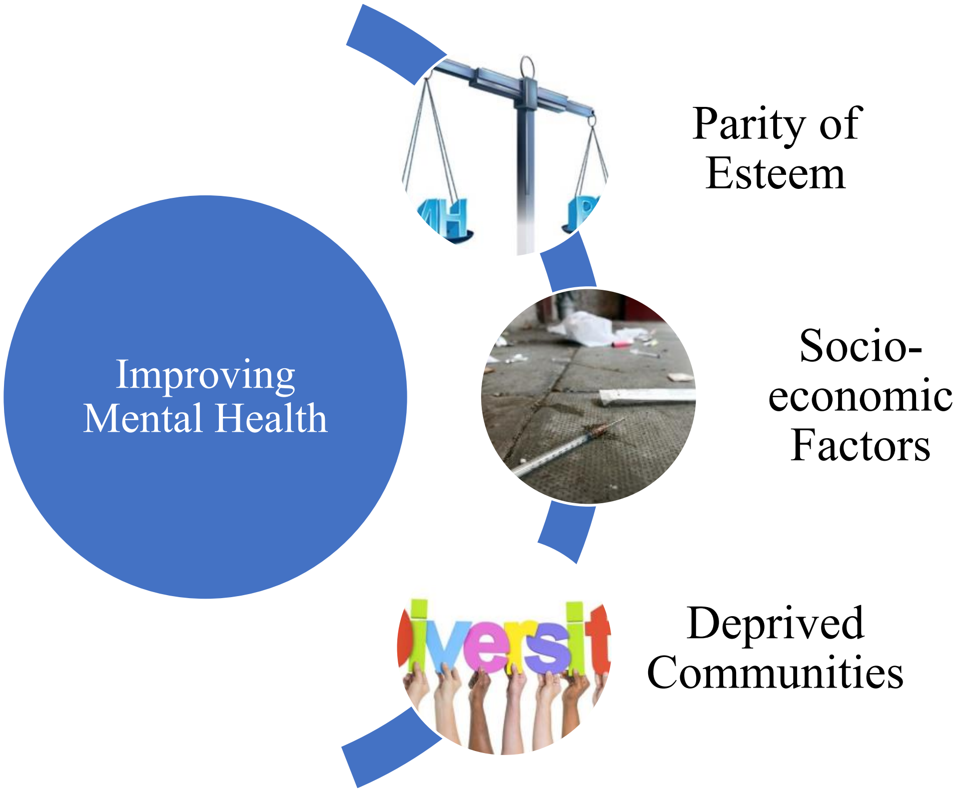
The research borough is a London borough with over 300,000 residents which has nearly three times more people registered with severe mental illness than the national average. The borough has a diversified ethnic population that identifies with a wide range of cultures and backgrounds, as covered in chapters six and eight under sections 6.2.1.3, 8.3.2.2, and 8.3.2.5.3. About 43 percent of the residents are from Black, Asian, and Minority Ethnic (BAME) communities, which rises to 60 percent when white other people are included. This contrasts with England, where more than 80 percent of the population is categorised as White British. Compared to the London average, the research borough had a relatively high burden of severe mental illness. For instance, among GP patients older than 18, 1.4 percent suffer from a serious mental disease (defined as patients with schizophrenia, bipolar affective disorder and other psychoses). A nationwide rate of 0.92 percent was recorded for England in 2016 –17, whereas the rate in London was 1.1 percent higher. Depression and other common mental illnesses are also common in the borough, where 8.5 percent of people over 18 are on the depression register.

The prevalence of severe mental illness among Black residents is disproportionately high. When compared to your white British equivalent in the research borough, people of black heritage are twice as likely to have a severe mental illness and are more likely to be sectioned under the Mental Health Act. According to GP records, 1.4 percent (1,370) of people with white British heritage were diagnosed with severe mental illness. Among those from black backgrounds, severe mental illness was reported in 2.8 percent (1,900) of the population. National data on contact with mental health services shows that black people are more likely to arrive in services with more severe mental ill-health, have greater contact with the police, and are more likely to be compulsorily detained under the Mental Health Act and restrained whilst in hospital.

All the seven collaborative-related policies were intended to improve the health of and reduce health inequalities for people in the local authority, which is one of the social issues these policies intend to tackle. The documents explored the way of working, a culture that unites everyone, how *The Collaborative* organised services around people and places and how the services were brought together as a whole system – the strategic alliance. All documents emphasised the importance of national and local policy in driving change throughout mental health services in the research borough. In particular, 'Confederation Proposal' stated the influence of the national policies such as 'No Health without Mental Health', 'Five Year Forward View for Mental Health' and 'Sustainability and Transformation Plans' in developing *The Collaborative*'s processes. The policy intentions of the documents were to create new governance focused on 'best for local people', develop integrated management and coordination for the local authority, create a single set of outcomes that show a whole system approach and develop new financial arrangements that move away from organisational silos to support and services around people.

The analysis of the collaborative documents using Jupp and Norris (1993) analysis framework (Appendix 9), resulted in the emergence of two main themes: *Parity of Esteem* and *Mental Health Inequalities.* Under the Mental Health Inequalities, *Socio-economic Factors* and *Deprived Communities* have been identified as the sub-themes.

Figure 5.1 Documentary Analysis Themes



Policy documents have responded to improving the integration in the three ways presented in Figure 5.1 above: by promoting the equal value of mental and physical health, identifying health inequalities due to socio-economic factors, and identifying the need to put emphasis on responding to the needs of deprived communities. The sub-themes identified under socio-economic factors in the policy documents are stable employment and housing; and stigma and discrimination. The deprived communities, such as BAME, and the people with disabilities represent inequalities in the mental health services in the policy documents.

Because of the tight link between mental and physical ill-health, the common underpinning principles of the policies are that the NHS co-ordinate services around the individual rather than treating patients in specialised silos and that medical conditions and preventative health care should be given significantly greater emphasis. A key indicator of parity is making mental health a key focus and giving it enough attention as part of broader initiatives to enhance health care and it is one of the principles underpin all the local documents analysed. There is a body of evidence that suggests treating mental and physical health issues jointly is beneficial for individuals and can save money. People who are impoverished are more likely to have bad health. Despite advances in income, scholastic performance, the percentage of people working in executive professions, and healthcare spending in Europe, the socio-economic disparity in health persists.

The effectiveness of multiple methods in tackling health inequities rests on strong collaboration being built between diverse institutions, one of the administrative arrangements explained in the London borough documents such as ‘Joint working between Council and NHS’ and ‘Transforming Adult Mental Health Services and Support – The Collaborative’. With a proposal for local strategic partnerships (LSP) across diverse components of the government, commercial and volunteer organisations involved in service delivery, the notion of partnerships between organisations was presented in The NHS Plan (Department of Health, 2000b). ‘Strong and Prosperous Communities’, the white paper (Department of Communities and Local Government, 2006), reaffirmed the importance of multidisciplinary engagement while also suggesting that people and society have more control over local services. ‘Joint Strategic Needs Assessments’, LSPs, ‘Local Delivery Plans’, and ‘Local Area Agreements’ are being used to identify the needs of the community and carry out the health disparities strategy (Department of Health, 2008b). Subsequently, the social issues that the local policies tackle, policy intentions, administrative arrangements and policy outcomes are drawn from these policy documents.

In disadvantaged communities that have long been neglected, there are chronic and recurring issues (Department of Health, 2006b). To promote fairness and guarantee that everyone has a realistic option, the government plans to enhance the provisions in places that are not well serviced — these are often in the most deprived places. There are several government policies, initiatives, strategies, and movements aimed at reducing health disparities and closing the gap between impoverished and wealthy populations. All analysed London borough documents employ this as their guiding premise as individuals with mental disorders who were the most deprived had more A and E visits and emergency hospitalisation than those who were the least needy. The major concepts have now been thoroughly examined. Now, the main themes are explored in detail.

5.2.1 Parity of Esteem

People with mental illnesses frequently do not have the same access to resources or receive the same level of care as people with other illnesses, according to a long-standing complaint of health and social care (Naylor, 2017) and this is one of the social issues that all the local documents tackle. One of the main themes identified in this paper is parity of esteem which concerns the principle by which mental health must be given equal priority to physical health. It is about helping to ensure that individuals with mental health issues have equitable rights to the most appropriate and efficient diagnosis and services; making equal endeavours to enhance the quality of healthcare; ensuring the equitable distribution of time, commitment, and assets based on the perceived necessity; holding similar levels of importance within the realm of health care curriculum and training; elevating expectations for patients, and dispensing fair treatment in health outcomes measurement (Elizabeth et al., 2018). All the documents emphasised the importance of this theme, which is highlighted as a policy aim.

As a result of the new approach, several policy developments and programmes have been implemented, including crisis services, funding, and special systems of care. Re-focusing on the equal value of physical and mental health has been emphasised in recent legislation. A strategic approach to improving mental health outcomes for people of all ages was employed in March 2015 when the mental health task force was formed (NHS England, 2015a). The Five Year Forward View (NHS England, 2014) aspires to break down the barriers between mental and physical health to *'achieve a genuine parity of esteem between physical and mental health by 2020'.*

There is a close connection between physical and mental health. People with serious and protracted mental health issues are, on average, at risk of death 15 to 20 years earlier than others. This is one of England's biggest health disparities (NHS England, 2018). Two-thirds of these fatalities are due to preventable diseases, such as heart diseases and cancer, many of which are caused by smoking. In addition, those with mental health disorders have no access to physical care. By February 2023, less than one-third of people with schizophrenia had been receiving a prescribed cardiovascular risk assessment in hospital. One of the collaborative outcomes is for service users to recuperate and remain healthy and enhance physical and mental health quality of life and it accords with the outcomes emphasised in the document, 'Confederation Proposal.' The objective and the administrative arrangements of *The Collaborative* to address and manage the 'physical health of people' measures the proportion of individuals as follows:

- percentage of individuals registered as smokers
- percentage of individuals documented by a typical weight of the body
- percentage of individuals registered with SMI

- yearly health tests and GP visits
- action plan for health
- proof of improvement on the action plan on health

Mental health represents 23 percent of NHS activities, according to The Five Year Forward View on Mental Health (NHS England, 2016), while the NHS expenditure on secondary mental health services is equal to only 50 percent. Years of low priority have caused CCGs to under-invest in physical healthcare services, but the degree of difference has mostly been disguised by how mental health expenditures are lumped together and reported, as opposed to physical health expenditure, which is broken down into particular ailments. Per capita spending on CCGs fluctuates around roughly double the fundamental requirements, leading to poor policy implementation.

Due to the significant interrelationships between physical and mental health, all mental health efficiency needs to be considered carefully so that false economies and increased expenses are avoided elsewhere in the health and social care systems. As the cross-London borough policy, 'Joint working between Council and NHS' outlines, one of the administrative arrangements identified for the policy was setting up *The Collaborative*, in response to recommendations from the national policies 'No Health without Mental Health', 'Five Year Forward View for Mental Health' and 'Sustainability and Transformation Plans'. In addition, the challenges facing the London borough, including 40 percent reductions in social care funding from 2014/15 has led to the implementation of *The Collaborative*. The analysis of the local documents revealed the social issues tackled as people with severe mental illness do not always receive the optimal treatment for their physical health requirements, and 30 percent of people with a long-term ailment also have poor mental health. STP's ground-breaking initiative in this field has resulted in the improvements in acute care demand seen in the Three Dimensions for Diabetes pilot (3D4D). Another programme is underway to investigate other solutions for enhanced integration and to guarantee that physical health treatment for people with SMI is streamlined, according to the administrative arrangements of the local document, 'Service User not System.'

5.2.1.1 An Integrated Mental and Physical Health Approach

All the documents recommended an integrated approach to mental and physical health, yet with differences in how this can be implemented. The local document, 'Transforming Adult Mental Health Services and Support – The Collaborative', illustrates the policy outcomes, that aligns with the collaborative outcomes to recuperate and lead a healthy lifestyle, enjoying enhanced levels of wellbeing in both physical and mental health. Power is allocated through this policy owing to the impact of The Five Year Forward View for Mental Health (2016) as it highlights '*making physical and mental health care equally important means that someone with a disability or health problem won't just have that treated, they will also be offered advice and help to ensure their recovery is as smooth as possible, or in the case of physical illness a person cannot recover from, more should be done for their mental wellbeing as this is a huge part of learning to cope or manage a physical illness*.'

South East London STP (SEL STP) (NHS England, 2015b) has recognised a desire to enhance mental health in the area, particularly the relationship between mental and physical health. One way the services could help people with mental health issues is to perform better in meeting their needs in certain fields. An example of this is the SEL boroughs' levels of mental health need which stand above the national average, as calculated using the PRAMH algorithm. Due to the greater risk of physical illnesses, those with serious mental illness may have shortened life expectancy of 13 years. When it comes to mental health, research has revealed that socio-economic conditions, population movement, and ethnicity are some of the most significant risk factors in the country. According to SEL STP (2015), severe and enduring mental health problems, such as schizophrenia, are closely linked to an extreme life expectancy gap, and addressing the mental health and wellbeing of people with physical health problems and long-term conditions and medically unexplained symptoms are critical to improving the wellbeing of all. It is crucial to emphasise the increased focus. One of the above local documents, 'Integrated Alliance – Adult Mental Health', provides the administrative arrangements on helping people's physical health alongside their long-term mental illness.

According to SEL STP (2015), the system is skewed towards hospital care as the policymakers do not invest enough in community-based programmes that keep people healthy or that help individuals with their emotional and physical wellbeing. The fact is, patients end up at the hospital when they could have benefitted from a greater focus on the community and yet, the ongoing debate is that people cannot stay in hospital too long as the discharge teams are pressurised to show people out as soon as possible. Therefore, the strategy for the NHS and social care services should recognise the importance of parity of esteem in community settings. Patients frequently remain in hospital for a longer time due to community-based plans for their medical care upon discharge have not been implemented.

As per the local document called 'Integrated Alliance – Adult Mental Health', an important feature and the administrative arrangement of the integrated service offered by *The Collaborative* is the

Alliance Rehabilitation Team (ART), which shows exactly how specialists across volunteer and statutory institutions may collaborate to better help persons in need. A multidisciplinary team made up of personnel from the volunteer sector, social workers, nurses, occupational therapists, and consultant psychiatrists is dedicated to integrating social and clinical care assessment, support, and coordination. The team members are supporting those who would have previously been admitted to the hospital by providing them with extra home-based care. They provide outreach to patients who need inpatient therapy even after being discharged. Some of the key objectives within the mental health element of the STP are to: • improve community mental health services and ensure that people are able to access crisis care or home treatment teams at any time • increase digital maturity in mental health services • improve mental health awareness and • ability to manage mental health conditions in the community. These, among others, are closely aligned with the objectives of *The Collaborative,* as illustrated in the policy outcomes of the London borough documents, 'Integrated Alliance – Adult Mental Health' and 'Together Integrating and Transition Programme.' The Collaborative Alliance, albeit on a smaller scale, have implemented the collaborative leadership and co-ordinated whole system approach embodied by the STP.

The local authority system will only be transformed and become cost-effective if we invest in community-based care (CBC). For the next five years, the SEL STP (2015) has set a goal to broaden visible, pragmatic, and preventative CBC for mental and physical health problems outside of hospitals by synchronising services, implementing multi-professional collaboration, providing impactful housing and meaningful occupations, and increasing team training within Local Care Networks. The Collaborative Alliance is satisfied that mental health services are at the forefront of integration within the local government. However, more must be done in the research borough to bridge the gap between physical and mental health. Over time, their ambition is to expand the collaboration's authority to include further services such as physical health services to its mandate. This will be done strictly in accordance with the rules on procuring and competitiveness.

5.2.2 Mental Health Inequalities

All the collaborative documents reflect on the impact of mental health inequalities, and this is the second theme to have emerged from the policy analysis. Inequalities exist across a range of dimensions, such as socio-economic deprivation and between ethnic groups (Connolly, Baker and Fellows, 2017).

One of the national policies driving change in the London borough for improving mental health is No health without Mental Health (2011). According to this, there are three aspects to reducing mental health inequality:

- Addressing the disparity that causes low mental health levels.

- Addressing the disparities that arise as a result of low mental health levels, for example, fewer work opportunities, and poorer housing, education and physical health, and

- Redressing the disparities in service provision, to the extent that they include the foundation, the processes, and the outputs.

No Health without Mental Health (2011) examines the conditions that foster wellbeing. The 'Joint Strategic Needs Assessment' (JSNA) and the new Health and Wellbeing Boards are vital to ensure that the commissioning of primary health services meets local needs and that emerging health inequities are addressed, as a result tackling the local social issues. The influence of this national policy has facilitated the research borough in establishing the Health and Wellbeing board, as illustrated in one of local documents analysed in Table 5.1, 'Establishing a Health and Wellbeing board for the London borough'. The Marmot findings indicate that inadequate childhood conditions, overcrowded housing, and low employment and unemployment are all variables that raise the risk of mental health disorders and which contribute towards the timing and outcome of any eventual recovery. Some groups are affected by these social and cultural issues, which result in them experiencing numerous disadvantages.

5.2.2.1 Socio-Economic Factors

Socio-economic factors were identified as one of the sub-themes to have emerged under mental health inequalities. The relationship between socio-economic factors is an underpinning negotiation in policy documents, one which aims at informing the integration agenda, and, specifically, identifying inequalities in the mental health services. *Socio-economic status* (SES) is a term that social scientists such as Krieger, Williams, Moss and McGee have used to capture several different factors. It refers to a person's income level, education, and general position in society (Marmot, 2004). It is essentially a combined measure of how individuals are performing.

Figure 5.2 Relationship between Health and Social and Economic Factors

As is seen in Figure 5.2, we can develop virtuous cycles of health and socio-economic wellbeing, as well as vicious cycles of health and socio-economic inequality that remain in place if we fail to address the root causes of the problem, which are often complex social issues. Investing to enhance and sustain healthy life through action on social determinants is crucial (Lovell and Bibby, 2018), as evidenced by the majority of the analysed research borough documents.

In studies of both adults and children in the industrialised world, significant relationships between SES and mental disturbance have been observed (McLeod and Shanahan, 1996). Local documents, ‘Integrated Alliance – Adult Mental Health’, ‘Confederation Proposal’ and ‘Service User not System’ demonstrated the administrative arrangements of addressing social and economic conditions such as housing, employment conditions and health services implicated in health inequalities in the research borough. Many of these arrangements are concerned with the physical health implications of substandard living conditions. While socio-economic health gradients are extensively documented using this range of indicators (Adler et al., 2000), no research assesses simultaneously the relative impact of absolute and relative SES, subjective social status and community inequality in mental health prediction. I am also aware of no research into the interrelationship of socio-demographic groups and different dimensions of SES and mental health. However, according to the local document, ‘Integrated Alliance – Adult Mental Health’, the correlation between low SES with mental illness has revealed that these differences are possible in racially diverse or ethnic groups (McLaughlin et al., 2012). No Health Without Mental Health (2011) emphasises the importance the Government gives in recognising that our mental health plays a major part in our standard of living. The findings of the analysis reveal the links between achievements in education, skill development and jobs, and addressing societal challenges, arising from poverty, violence and criminal activities.

5.2.2.1.1 Stable Employment and Housing

The 'Confederation Proposal' suggests that employment security and housing are variables in helping someone to keep excellent psychiatric health and which show significant results of recovery when a mental health condition is diagnosed. It continues to stress that 60-70 percent of people with typical psychiatric issues are employed but few have access to specialised vocational medical care, as emphasised in the 'Five Year Forward View'. There is a 65 percent employment gap relative to the general population among those assisted by secondary mental health care. People with difficulties with mental health are generally disproportionately represented in high, low-paid and often part-time or temporary employment. Common mental health issues are more than double and psychosis up to 15 times higher for homeless people when compared to the general population.

A number of indicators in this research borough are known to expose people to mental health problems, including significant levels of poverty, overpopulation and the possibility of becoming homeless. The challenges of mental health are also interrelated with a series of health inequities in the studied borough; among them are over-representation of the Black population in the mental health system, and those with mental health problems who are physically ill, discriminated against, unemployed or socially isolated. One of the three collaborative outcomes is for people to participate in everyday life on an equitable basis, in particular with regard to education, jobs, appropriate earnings and secure living, and to tackle stigma and discrimination. The policy outcomes of most of the local documents and a critical part of *The Collaborative*'s provision is the housing supply and enhanced combined cooperation between providers of housing and mental health services. One of the key issues that all local authorities face is insufficient housing stock. It will have an impact on the ambitions of *The Collaborative*. The supported housing scheme for nine units in the local authority is another system particularly created for the Integrated Alliance and it is the administrative arrangement for the local policy, 'Transforming Adult Mental Health Services and Support – The Collaborative'.

The unemployment level in individuals with mental health difficulties is unacceptably high, according to the Five Year Forward View for Mental Health (2016), with 43 percent of all individuals with mental health conditions in occupation as opposed to 74 percent of the overall population and 65 percent of persons with other disorders. Only 9.5 percent of those with 'mental and behavioural difficulties' have been assisted in jobs, a smaller proportion than several effective schemes. There is a 65 percent gap in employment rates between those with more severe health issues, assisted by specialised mental health treatments, and the general population. A policy outcome from the local policy confirms that jobs and wellbeing form a virtuous circle: appropriate employment may be excellent for your wellbeing and good health enables you to have a higher likelihood of working. The Five Year Forward View for Mental Health (2016) has also predicted that every year, by 2020/21, up to 29,000 more individuals living with mental health difficulties could be encouraged to find or remain in employment by improving the access to individual placement and support in psychological treatments for common mental health disorders and expanding access to Individual Placement and Support (IPS). In reality, there is no evidence to confirm these figures.

Housing plays a crucial role preventing mental health issues and promoting rehabilitation (Mental Health Foundation, 2016). According to a desired policy outcome of two of the research borough documents, 'Transforming Adult Mental Health Services and Support – The Collaborative' and 'Integrated Alliance – Adult Mental Health', the Department of Health, the Department of Communities and Local Government, NHS England, HM Treasury and other agencies should work with local authorities to strengthen the evidence basis for specialised housing support for vulnerable persons with mental health disorders and study the case for leveraging the use of NHS and local authority land to make additional assisted homes accessible for this population.

By looking at the progress and track record of alliancing, the collaborative network was formed in 2015, as an administrative arrangement of a local policy, following a prototype that started in 2013, providing people with open access to holistic support on a range of 'social' as well as 'health' issues, such as housing and employment support. To date, this multi-agency, multidisciplinary service has helped to increase the numbers of people accessing support, accepting over 500 introductions per month and reducing the number of referrals into secondary care by 43 percent. As a result of local policies, one risk of the initiative is that the Provider Alliance Group (PAG) will be transformed in order to improve communication with services that the CCG and local authority commission, such as housing and employment services. Creating a housing strategy and getting people involved in its implementation will increase buy-in.

Based on the Sustainability and Transformation Plan (2016), LCN will deliver a spectrum of community-based solutions by calling on others from the healthcare, social and volunteer sectors. According to the policy intentions of most of the local documents, in the end, the aim is to incorporate the whole community-based system, which drives reform in sectors such as housing, with conventional health and care stakeholders. At present, this covers the provision of several high impact systems, including provisions such as enhanced step-up and downsizing and the prevention of admission for specific members of society.

5.2.2.1.2 Stigma and Discrimination

In accordance with ‘Integrated Alliance – Adult Mental Health’ document, stigmatisation and discrimination by the community, family, friends, and employers exacerbate many people's issues. The mentally ill, the least likely of any group of people with a long-term health condition or impairment, is, nevertheless, struggling to get the care and treatment they need to:

- Seek out employment
- Be in a serious relationship for a long time
- Take responsibility for their own living situation
- Maintain social connections in the mainstream.

as highlighted as the social issues to tackle by the local document, ‘Transforming Adult Mental Health Services and Support – The Collaborative’ and emphasised in the Five Year Forward View for Mental Health (2016). As a result, society as a whole has negative stereotypes about mental ill-health and the people who suffer from it. The public mistakenly believes that those with mental illnesses are aggressive and are a danger to the local community, although they are more likely to become a victim of violence or injure themselves than they are to harm others. Stigma and discrimination, which are social issues that local policies tackle, can exacerbate mental health issues, making rehabilitation more difficult (Mental Health Foundation, 2017). It can also trap people in a cycle of illness.

The Collaborative was looking at the possibilities of forming Time to Change platform in the local authority. People with lived experience of mental health disorders, often known as champions, as well as government entities, CCGs and voluntary sector organisations, made up the Time to Change initiative. Its goal was to use local expertise to help neighbourhoods, businesses, and schools minimise adverse thoughts and perceptions about anyone in their community who was dealing with mental health issues. The campaign would empower people who have personal experience with mental health problems to be the cornerstone of all of the work. *The Collaborative* shared and approved the idea, underlining the necessity of creating opportunities for members of the community to speak up about their experiences and those of their peers with lived experience of mental health challenges. This is a step-change, but they have waited eight years and intervention from the external organisation Time to Change to recognise the importance of stigma and discrimination.

5.2.2.2 Deprived Communities

Equality and human rights are among the goals of the mental health outcomes strategy. To minimise disparity and to improve the wellbeing of the population, we must focus on people's human rights (Elliott, 2016). Ensuring health outcomes that are among the finest in the world hinges on tackling health inequities and supporting equality as legislated in the Equality Act (2010). Therefore, the policy documents have identified the policy intentions to reduce mental health inequalities among the deprived communities, by giving priority to BAME communities and people with disabilities, as detailed below. Marmot's review revealed that England's poor health results compared to similar nations may be explained by the socio-economic gradient in health outcomes for disadvantaged populations and locations. One of the underlying principles for the analysed documents highlights that when there are issues around personal identification and experiences of inequality, aspects of people's identities and experiences interact with each other. For example, individuals who belong to BAME groups are more likely to live in neighbourhoods with subpar conditions and have unpleasant experiences as a result of their ethnic identity and socio-economic position, as well as the location where they live, a social issue tackled by the local policies.

5.2.2.2.1 Black, Asian and Minority Ethnic (BAME)

The Five Year Forward View for Mental Health (2016) states that marginalised groups are particularly vulnerable, including people from the BAME community, lesbian, gay, bisexual, and transgender people, people with disabilities, and individuals in interactions with the system of criminal justice, one of the social issues tackled by the local documents such as ‘Joint working between Council and NHS’ and ‘Transforming Adult Mental Health Services and Support – The Collaborative’. The chance of living in substandard or congested housing increases the likelihood of mental health disorders for BAME individuals, another social issue tackled by the London borough documents ‘Transforming Adult Mental Health Services and Support – The Collaborative’ and ‘Confederation Proposal’. Use of the Mental Health Act (1983) will be monitored, with a focus on BAME groups. In the local authority, people from BAME communities and individuals who are admitted repeatedly to psychiatric hospitals are over-represented in hospital beds. The fact that members of Black communities are more frequently represented in services based on acute beds is a fundamental problem expressed in the context of the 2014 Collaborative Commission and social issue, that the local policies attempt to resolve.

In 2013/14, there were 198 fatalities of those who were being held under the Mental Health Act, the majority of which were due to natural causes, such as avoidable physical illness. The research borough document published in 2012, ‘Integrated Alliance – Adult Mental Health’ confirms that Black, minority ethnic communities, young persons who do not have solid backgrounds, and many others can fail when mental health services do not function. If they function effectively and cooperate effectively with local agencies in the public, commercial and voluntary sectors, they assist people in overcoming their disadvantage and help them to realise their actual potential. As a result, this mental health initiative and the policy intentions of ‘Transforming Adult Mental Health Services and Support – The Collaborative’ is both a public mental health and a social justice strategy. Collaborative Thrive (CT) is an initiative working with *The Collaborative* in improving mental health and wellbeing for the local authority’s Black communities. As part of the administrative arrangement for the 'Confederation Proposal' document, a shadow alliance board composed of providers and commissioners was established in September 2017 to forward the development work and negotiating process. In October 2017, the director from CT joined the shadow board, thereby strengthening the working relationship between CT and the Integrated Alliance.

Seni's Law, which restricts the use of force against patients in mental health facilities, is a win in the fight to safeguard people when they are imprisoned in institutions under the Mental Health Act 1983, a social issue addressed by the local mental health documents on inequalities. The amendments will compel NHS trusts to make patient restraint practices more transparent, including requiring police officers to wear body cameras when dealing with vulnerable persons. Seni's Law is named after Olaseni Lewis, who died in September 2010 at Bethlem Royal Hospital in south-east London after being detained by 11 police officers. In 2017, mental health facilities employed restraint 97,000 times, harming 3,652 people. Despite the fact that this measure is named Seni's Law in honour of Seni, it has impacted many others who have died or been harmed just because they were ill. Power is allocated through the local document, ‘Together Integrating and Transition Programme’, by taking the responsibility to ensure that safe mental health treatments are accessible to everyone.

For some years, addressing inequities affecting BAME communities has been a top priority. However, the results have been underwhelming in certain aspects. People from BAME communities were concerned, according to the Five Year Forward View on Mental Health (2016), since they had lost faith in the systems and desired greater community help. Aiding populations such as BAME communities, who are currently underserved by institutions, is a key priority for the community and voluntary sector providers. *The Collaborative* will be considering addressing the disparities that individuals with mental illnesses face and doing so with parts of that population, including people from black communities who are over-represented in acute mental health services, a commitment explained and policy intentions of the local document, ‘Integrated Alliance – Adult Mental Health’. The Race Equality Action Plan: A five-year review (Wilson, 2010), through which power is allocated to some local policies and action plans, discusses some of the significant problems, triumphs, and lessons from the work of implementing race equality in mental health treatment. It offers a solid foundation for commissioners and service providers to build on. Such a foundation and the real and desired policy outcomes of the analysed local documents would include:

- Information on ethnicity and culture being collected and monitored on a local level.
- The use of this data to better guide health and social care commissioning and provision.
- A focus on achieving positive results for people and communities.
- The monitoring and assessment of the efficacy of delivery of services, particularly in relation to equity issues, and
- The creation of systems that enable local user groups to interact with providers and commissioners, as well as empowering and supporting them to do so successfully.

The Collaborative Alliance will also be required to focus on healthcare inequity and seek to prevent it from becoming a problem. This is especially true for particular objectives set by local governments, such as those established in the joint commission. The collaborative commission report, released in 2015, emphasised the necessity of co-producing services with users and praised *The Collaborative*'s efforts. The commission, as highlighted in ‘Transforming Adult Mental Health Services and Support – The Collaborative’, emphasised the need for providing earlier and more accessible help as a method of lowering the disproportionate frequency of adults from Black communities in crisis-orientated or coercive mental health care, like forensic services.

5.2.2.2.2 People with Disabilities

The consideration of the outcomes for disabled individuals with mental health disorders has two parts (National Institute for Health and Care Excellence, 2016):

- People with mental illnesses satisfy the standards outlined in disability laws, and
- Disabled people with mental illnesses may confront obstacles, such as physical hurdles or communication impediments (particularly in the case of deaf people). This is especially important in

mental health care, where improved results are strongly reliant on conversation and interactions. In addition, it is believed that 25–40 percent of persons with learning difficulties have mental health issues.

According to the Sustainability and Transformation Plan (2016), SEL has some of the highest levels of risk variables in the country, based on an examination of the causes of mental health need, such as poverty, population movement, and multiculturalism. The policy outcomes of the local documents 'Transforming Adult Mental Health Services and Support – The Collaborative' and 'Integrated Alliance – Adult Mental Health' confirm *The Collaborative*'s goal for all residents of the local authority is that every inhabitant, regardless of their skills or limitations, may prosper, make a contribution towards the community, and live the life they choose to live. The integrated alliance approach would promote improved collaboration and co-production with local inhabitants, resulting in community plan outcomes such as aged, disabled and disadvantaged individuals being able to live independently and have authority over the assistance they require.

5.3 From National to Local Policy

The research borough's documentary analysis reinforces the assertion that national and local policy are driving transformation throughout England's mental health systems. High demand, fragmentation of services, inequalities, financial pressures, and national mental health policies such as 'No Health without Mental Health', the 'Five Year Forward View for Mental Health', and 'Sustainability and Transformation Plans' are highlighted as drivers of change in the 'Confederation Proposal', one of the documents analysed (Table 5.1) of the London borough.

'No Health without Mental Health', a government-wide strategy released in 2011, made specific mention of expanding access to preventative care and the importance of tackling social and economic factors that have an impact on people's mental health. The Five Year Forward View for Mental Health (2016) expanded upon earlier efforts to improve mental health and reaffirmed the significance of preventative, comprehensive care. Although it also highlighted the possibility of new contractual methods to stimulate collaboration and integration between services. The paper argues that the current separation of primary care from community, the lack of communication between healthcare providers and hospitals is becoming an increasing obstacle to patient-centered and coordinated care. By promoting providers' alignment on a single set of outcomes and encouraging them to work collaboratively to achieve them, *The Collaborative* helps local research borough implement new contractual models that are seen as crucial because they encourage integration between services and drive a focus on outcomes rather than activity.

‘Sustainability and Transformation Plan’ (STP)’s mental health objectives include: improving community mental health services and ensuring that people can access crisis care or home treatment teams at any time; increasing digital maturity in mental health services; and improving mental health awareness and the community's capacity to manage mental health conditions. These, among others, are closely connected with *The Collaborative*'s goals. *The Collaborative* applies, albeit on a lesser scale, the STP's collaborative leadership and coordinated whole-system approach. The formation of Local Care Networks (LCNs) is a further essential component of the STP. The documentary analysis findings confirm that *The Collaborative* is the adult mental health offer inside the LCNs in the research borough.

5.4 Chapter Summary

Chapter five has described the results of an analysis of seven collaborative documents, including health and social care and mental health policies, of the London borough under study to explore, in depth, the ways in which integration of health and social care has been implemented with regard to mental health issues of the population. The policy analysis represents the policymakers’ angle, social issues that the policy tackle, underlying principles, policy intentions, power allocated through policies, policy outcomes and how the policy documents have responded to improving the integration in these three ways: the promotion of equal value of mental and physical health; the identification of health inequalities due to socio-economic factors; and identification of the need to put emphasis on responding to the needs of deprived communities. The sub-themes identified under socio-economic factors in the policy documents were stable employment and housing; and stigma and discrimination. Deprived communities, such as BAME and people with disabilities, have been identified as receiving unequal access to mental health services in the policy documents.

CHAPTER 6: SEMI-STRUCTURED INTERVIEWS FINDINGS

6.1 Introduction

This chapter reports on the data collected via the semi-structured interviews with the stakeholders employed in leadership roles in *The Collaborative* and presents the themes that have emerged from the data by sharing excerpts from the interviews with the participants. The aim of the interviews was to manage the potential dynamics between the leadership of the five organisations under *The Collaborative* and their co-workers, while also guaranteeing that their ideas and views were collected.

Interviews are the most popular qualitative research technique (Frith and Gleeson, 2021), and their prevalence derives from their ability to be undertaken from a variety of epistemic perspectives (Frith and Gleeson, 2021). An interviewer will ask and probe a subject with the aim of encouraging participants to express opinions openly on a given topic. This is in contrast to the low-moderation method used in focus groups. These interviews were conducted using a semi-structured interview format. The questions were generated following a literature review and policy analysis. Probing questions were used so that the leaders within the organisation could elaborate on their thoughts in depth. The intention of using interviews as a method was to present comprehensive and thorough data on team formation and to address the research aims. The data collected from the interviews made a significant contribution to the research and the findings could result in better societal knowledge and possible policy development to improve the health and wellbeing of the people in the research borough and other London boroughs. A purposive sample of 13 senior leaders in *The Collaborative* (Table 6.1) was interviewed about their experiences within the organisation.

Table 6.1 Semi-Structured Interview participants

Number	**Job Title, Organisation**	**Number of Years with *The Collaborative***	**Gender**
1	Interim Alliance Director, Alliance Leadership team	5 years	M
2	CEO, Voluntary sector organization	7 years	M
3	Integrated Alliance Director, CCG	10 years	F
4	Assistant Director Integrated Commissioning (Mental Health), CCG	12 years	M
5	Head of Service, Voluntary sector organization	13 years	M

Number	**Job Title, Organisation**	**Number of Years with *The Collaborative***	**Gender**
6	Deputy Director, Borough Alliance, Council	2 years	M
7	Strategic Director, Integrated Health and Care, Alliance Leadership team	7 years	M
8	CEO, Voluntary sector organisation	2 years	M
9	Chair, Health and Wellbeing Board, Council	10 years	M
10	CEO, Collaborative Commission	5 years	M
11	Executive Director Strategy and Business Development, Collaborative Commission	10 years	F
12	CEO, Healthwatch	7 years	F
13	Chair, *The Collaborative*	10 years	M

It is important to note that participants comprised 10 males and 3 females. Nine of the participants had been employed at *The Collaborative* for seven years or longer.

6.1.1 Structure of *The Collaborative*

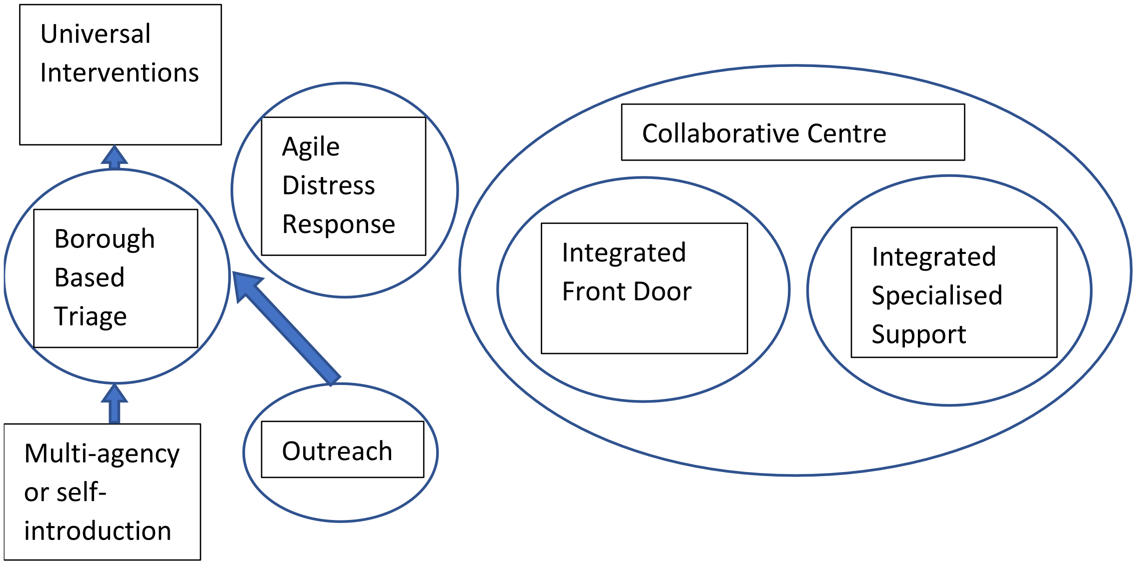
The integrated workforce of health, social care and community voluntary sector workers provides a blended model of interventions and provides care and support for people whose needs require more long-term interventions. The interventions include diagnosis; psychological therapies; medication management; structured case management; supporting improvements in physical health and risk management; benefit and housing support; occupation depending on the service user needs, and social inclusion. New initiatives have been created with more qualified CMHTs, Collaborative Centres, an organised peer support approach, Single Point of Access, a Community Options Team and interfaces between GPs, social care and mental health primary care.

6.1.1.1 Collaborative Centres

There are three Collaborative Centres in the London borough in question and most community-based mental health services are organised around this model. The centres ensure that people have a straightforward system to access the correct mental health intervention and associated support promptly. Each centre (Figure 6.1) includes an Integrated Front Door, an Integrated Specialised Support Community Service, A Rapid Distress Response and a Staying Well Service.

Figure 6.1, below, provides an outline of the centres' structure and associated wrap-around services:

Figure 6.1 The Collaborative Centre Form



The functions within each Collaborative Centre comprise an Integrated Front Door and Integrated Specialised Support. An Integrated Front Door, also known as the Single Point of Access, is an easily accessible entry point where people can access multidisciplinary and multi-organisational assessment and support. The Integrated Specialised Support provides a mixed model of health, social and community voluntary sector interventions. The triage function receives the majority of referrals for those people in need. The agile distress response service offers an on-the-day crisis assessment for those people identified in acute distress by the borough-based triage. The outreach service is envisaged to be an offer that is provided by several network providers to be part of the different communities that they serve, building trust and confidence between each community and the services available to them.

6.1.2 Similarities and Differences between Semi-structured Interviews and Focus Groups Themes

Table 6.2 Similarities and Differences

Themes	**Semi-structured Interviews**	**Focus Groups**
Theme 1	Underpinning Principles	Underpinning Principles
Sub-themes	Collaboration	Collaboration
		Multidisciplinary team working.
	Peer support	Peer support
	Empowerment	Empowerment
Sub-theme	Policy	Voluntary Sector Organisations
Theme 2	Successes and Achievements	Successes and Achievements
Sub-themes	Housing	Housing
	Education, training, volunteering or employment	Education, training, volunteering or employment
	Criminal justice	
		Person-centred care
		Outcome-based care
Theme 3	Challenges	Challenges
	Financial constraints	Financial constraints
	Stigma	Stigma
	Ethnic disparity	COVID-19
		Differences in staff culture

The combined analysis of the data from the 13 semi-structured interviews and the five focus groups revealed three main themes, which are shared across the two data collection methods (Table 6.2). The themes are *underpinning principles*, *successes and achievements*, and *challenges.* Theme one (underpinning principles) derive three sub-themes, which are collaboration, peer support and empowerment. These are also the same for both the semi-structured interviews and focus groups.

There are differences and variations in some of the sub-themes under themes one, two and three. For semi-structured interviews, for theme 1 – Underpinning principles, within empowerment there is policy. For focus groups, for theme 1 – Underpinning Principles, within the collaboration, there is multidisciplinary team working and the theme under the empowerment is the voluntary sector organisations. Under theme 2 - Successes and Achievements, for semi-structured interviews the sub-themes such as housing, and criminal justice, and education, training, volunteering or employment are derived. For focus groups, the two sub-themes of housing and education, training, volunteering or employment are the same, but there are additional themes, which are person-centred care and outcome-based care. For theme 3 - Challenges, the semi-structured interview data revealed the sub-themes of financial constraints, stigma and ethnic disparity, but for the focus groups, the sub-themes were financial constraints and stigma. In addition, COVID-19 and differences in staff culture are the derived sub-themes, noting the omission of ethnic disparity.

6.2 Interview Findings - Themes

The thematic analysis from the interviews identified three main themes: Underpinning Principles, Successes and Achievements, and Challenges. Three sub-themes were derived from Underpinning Principles, which were collaboration, peer support and empowerment (Figure 6.2). The theme under empowerment was policy. The sub-themes of housing and criminal justice and education, training, volunteering or employment were derived from Successes and Achievement (Figure 6.3). Theme three, Challenges, also revealed the sub-themes of ethnic disparity, financial constraints and stigma (Figure 6.4). All the three themes and the sub-themes contribute to the answering of the question: *How has The Collaborative facilitated the integrated care process for mental health outcomes in one London Borough*?

To represent the degree of participant response, descriptive phrases such as ‘all’, ‘quarter’, ‘half’ and ‘three quarters’ will be utilised. Participants were given a numerical code to safeguard their identities. To increase readability, some modifications have been made to the formatting of interview extracts. A dotted line in enclosing brackets (....) indicates the absence of words to reduce quotations. The insertion of text for the reader's benefit is indicated by square brackets [text]. For clarity, repetitions or filler words (e.g., ‘like') and hesitations (e.g., ‘errmm’) have been removed from extracts. The members vary from providers to commissioners, with some having served as both a commissioner and a provider in *The Collaborative*.

Figure 6.2 Semi-Structured Interviews Theme 1

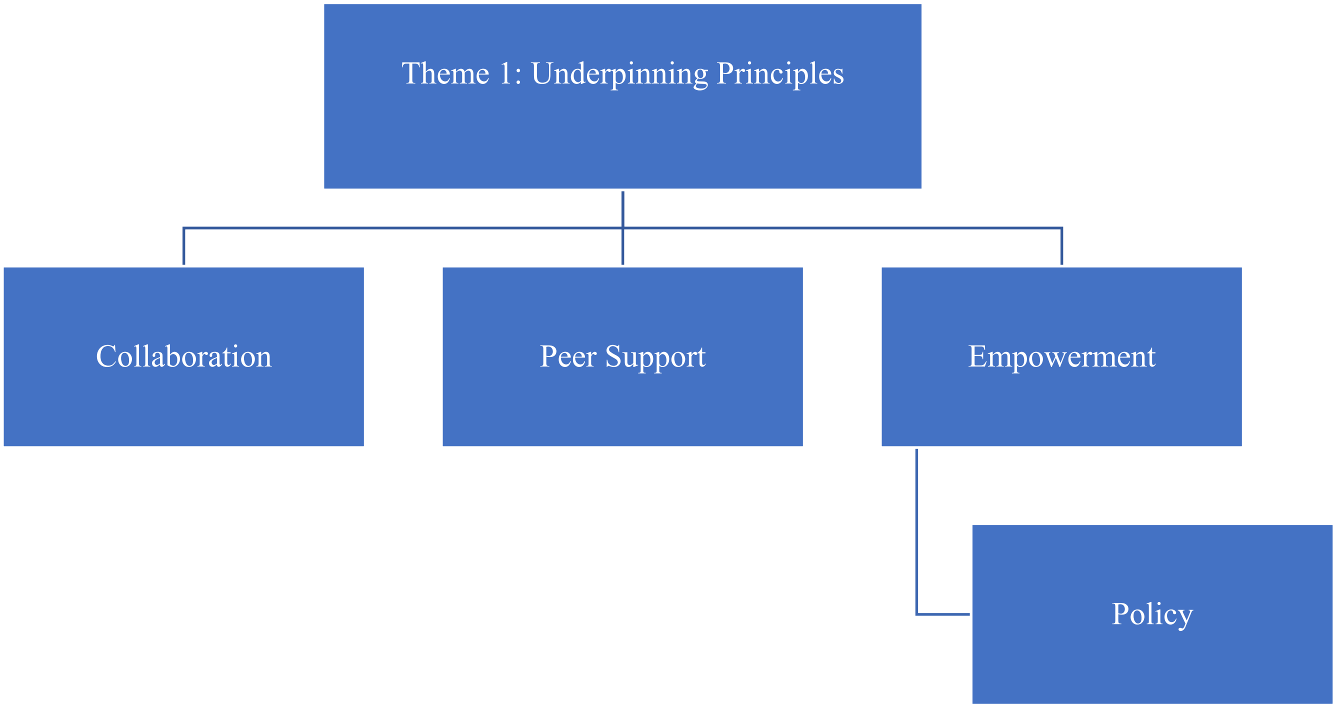


Figure 6.3 Semi-Structured Interviews Theme 2

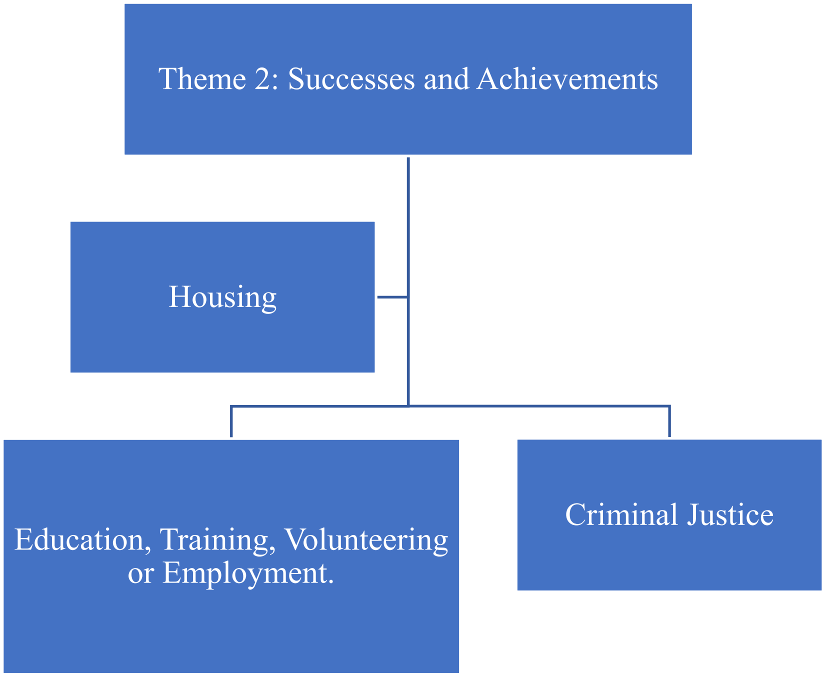
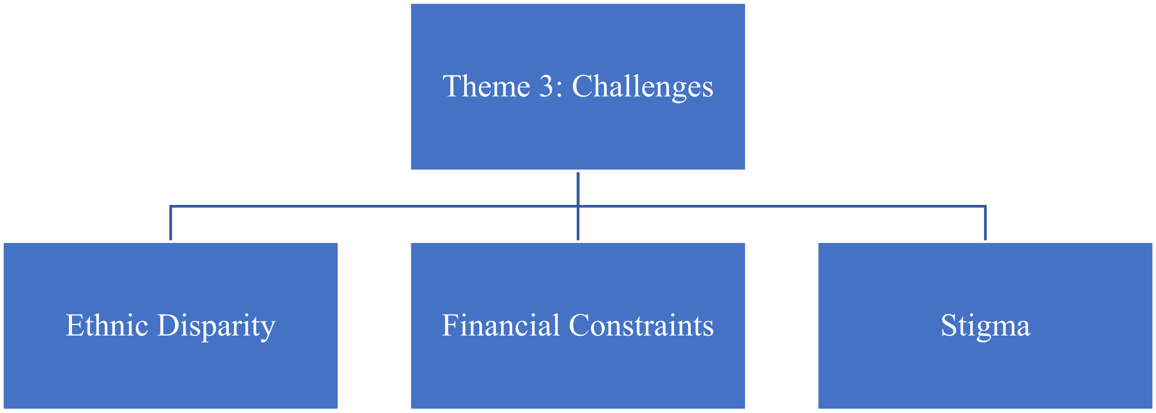


Figure 6.4 Semi-Structured Interviews Theme 3



6.2.1 Theme 1: Underpinning Principles

All the participants emphasised that the mental health provision in the London borough needed to be underpinned by a set of principles that distinguish that location from other geographical areas. This section takes these principles as the starting point, aiming to clarify how the mental health provisions are currently conceptualised to identify areas where the provisions can make a unique contribution to the population.

According to the participants, implementation of the best services to improve mental health requires very significant changes in the way the five partner organisations, for example, collaborative commission, which is an NHS Trust, clinical commissioning group, the council and the two voluntary sector organisations are planned, commissioned and delivered, characterised by a stronger emphasis on collaboration, peer support and empowerment. According to over three-quarters (N = 11) of the participants, if these principles are not reflected in practice, *The Collaborative* will not fulfil its potential for developing new approaches.

6.2.1.1 Collaboration

According to the participants, the partnership of service users, carers and commissioners across the NHS, the CCG, the council, the voluntary and community sector, secondary care, and primary care all being joined together helps to achieve better outcomes for those with severe and long-term mental illnesses. Some participants also referred to the co-production model, which is about fostering a more equitable partnership between service users, caregivers, and professionals. Co-production can help make the most of resources, boost productivity for service users and caregivers, strengthen communities and develop citizenship (Social Care Institute for Excellence, 2015). According to the participants, partnership working through co-production share authority and responsibility to develop, plan, analyse, and offer assistance jointly, which improves the relationship.

For the leadership team, collaboration emerged as a response to the problem of repeated assessments being carried out by different services.

> *"The services were working in silos, not achieving particularly great outcomes with residents and with the service users, who were saying "there have been far too many assessments". For the service users, if they move from one commissioned service to another commissioned service, they probably have to have another assessment. Collaboration of service was necessary to bring the different partners together."* (Participant 6)

The participants shared how, as a result of the partnership, service users were placed on a care pathway earlier and fewer service users were referred to acute services. Gradually, people were discharged from an acute setting into the community setting and some of the acute capacity was no longer needed. The whole system approach made them realise that there was overcapacity in the system and that the Collaborative Commission had closed one ward as *The Collaborative* was dealing with demand in a different manner. When asked the question of how the collaboration and partnership and work of *The Collaborative* had impacted the culture and ways of working for staff, one participant asserted:

> *"Usually, the closure of a ward would be something that clinicians would feel was wrong and it would have a long-term impact. People politically would have had a problem with that, but we all felt that the clients that we were dealing with were given a different and a better pathway."* (Participant 8)

The participants shared that by improving the outcomes for the service users, the partnership approach had financial, cultural, community and service user benefits. Working in a multidisciplinary way with the specialists and professionals to provide a correct care pathway was perceived to be enriching for the participants as it had improved the process for the community mental health team, the commissioners and the providers. For the leadership team, the financial benefits of *The Collaborative* were clear: in addition to utilising the existing skillset of the staff, they offered more services and solutions and introduced new revenue streams.

> "*On the financing, in terms of Integration Alliance, the initial budget was £12 billion and we were able to realise about £3 billion worth of savings. So, we turned to £9 billion and made the saving as a result of this better-coordinated care and bringing housing and social care and health and the voluntary and community sector together."* (Participant 2)

Austerity has disproportionately impacted the availability of key mental health services and in a time of austerity, it is quite significant to be able to provide a better service and save money by working in collaboration.

> *"Across the Collaborative Alliance, the budget is annually £65 million and we hope to be able to make savings of three to four million by working in partnership. Although in the first year, we have spent £70 million and it is because of the increase in demand and the setting up costs."* (Participant 1)

> "*Every month, the Collaborative Hub supports 470 people, many of whom had no previous access to help; that secondary care support had been reduced by 75 percent (from one month to one week); referrals to secondary care teams had been reduced by 25 percent, and the average cost per person was £103 - a low price for alternate secondary care.*" (Participant 9)

6.2.1.2 Peer Support

This section discusses the second principle captured from the participants and underpins the impact on people with mental health issues. The participants reflected that within *The Collaborative*, peer support and user co-production are at the heart of the Collaborative Network's delivery model. *The Collaborative* concept is that peer support is simply one person helping another, when both people have direct knowledge with mental health concerns.

> *"Peer support can be a useful complement or substitute to more typical therapeutic care. Peer support may serve a range of tasks, involving re-ablement, community cohesion, contextualising, and programme development since it is easily available and serves as a vital link between services and the community. It's also a vital co-production approach that bridges the gap between service consumers and experts. Peer support is about bringing people together in a secure, confidential, and quasi-environment to communicate and interact and offer helpful information intended to facilitate one another get through difficult times"* (Participant 6)

Participant 9 corroborated this by stating:

> *"Clinical therapy and formalised mental health services are important parts of many people's support systems, but they are restricted in terms of speed, availability, and expense for many people. Through peer support, The Collaborative is greatly increasing the standard of living for people and the outcomes they obtain in mental health care. This is because people may benefit from mutually supportive connections that aren't hampered by waiting lists, eligibility requirements or diagnoses"* (Participant 9)

Participants discussed how, in 2013, work that had already been done in *The Collaborative* to improve peer support led to the development of the Peer Support Manifesto, which was devised by the partners.

The participants displayed their knowledge of the different services which run as part of *The Collaborative*, and over half (N = 7) of the participants shared how *The Collaborative* had allowed the space for peer support to develop in three different ways, i.e., the talking shop, the peer support hub and 'collaborative in crisis'.

Participant 7 described the talking shop as:

> "*A weekly discussion session held by peer support workers for a group of nominated individuals who have been obtaining hub assistance. The peer support workers normally begin each session by asking each participant "How was your week?" and then the conversation moves on from there."* (Participant 7).

Participant 10 expanded, as she said that the peer support hub's support workers had completed a review in June 2017 and the findings from the review of the talking shop were shared:

> "*A survey was conducted to gather feedback on the talking shop. The programme was well-received as 83 percent said they would certainly or probably endorse it to friends. The talking shop has improved the mental health of 58 percent of those who participated. The talking shop is entertaining, builds confidence, and reduces people's feelings of loneliness*" (Participant 10)

When discussing the benefits of *The Collaborative* to the service users, the participants highlighted 'collaborative in crisis', which is a free out-of-hours phone service for people in crisis. *"We listen and give crisis support via skype, text and social media."* (Participant 2)

The service also provides a crisis peer support out-of-hours phone line for those in crisis run by peer supporters with lived experience.

> "*We offer community crisis support, a short-term crisis peer support service for people to avoid attending Accident and Emergency departments. The peer supporters have lived experience of needing mental health support and have been trained to support others*" (Participant 13)

One participant summed up the peer support:

> "*We now aim to dramatically expand and strengthen peer support so that anyone receiving mental health care may provide or request assistance from another person who has lived experience. The peer support framework was established to openly declare our ambition to growing and connecting the numerous peer support programmes so that peer support becomes an integral element of the borough's service offering*" (Participant 6)

The Collaborative has facilitated improved outcomes for the service users through peer support to achieve the collaborative outcomes, i.e., recuperate and maintain good health, resulting in increased quality of life.

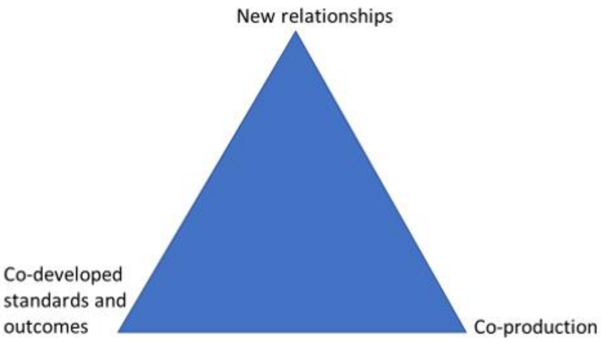
6.2.1.3 Empowerment

The third sub-theme that was derived from the semi-structured interviews under the underpinning principles is the importance of the empowerment of the service user in adopting partnership principles for the mental health provisions within *The Collaborative*. People with mental illnesses have historically been denied a voice. They and their families have been excluded from mental health decision-making, and they continue to endure social marginalisation and prejudice in many aspects of life. Empowerment in the context of mental health represents the extent of power, influence, and freedom that consumers of mental health services have over events in their life. The elimination of legal and unofficial obstacles, as well as the alteration of power relations between people, communities, services, and governments, are critical to empowerment (Laverack and Pratley, 2018). This statement relates to *The Collaborative*'s actions to promote service user and caregiver empowerment in mental health, as well as *The Collaborative*'s user empowerment partnering aims.

As *The Collaborative*'s holistic collaborative outcomes were developed after the consultations with the stakeholders, service users and staff, over half (n = 7) of the participants expressed the view that measuring the service user and the staff satisfaction against the performance framework was necessary. The collaborative outcomes are stated in Appendices 4 and 5, interview guide and focus group guide respectively.

A contract between commissioners and a coalition of suppliers who provide the program or service, known as an alliance contract, can take a variety of forms. The armoury of alliance commissioning arrangements (Figure 6.5) has three major connected features that, if effective, can resolve the challenges associated with the conventional approach.

Figure 6.5 Alliance Contracting and Commissioning: 3 Key Elements



The Collaborative is an example of alliance commissioning and contracting and the participants expressed that they wanted a transformed system. On the question of the delivery of *The Collaborative* and how the different organisations support and influence the delivery in impacting the mental health of the population, participant 2 described a recurring whole-system discourse about the transformation that was based on co-production principles, which valued all voices and viewpoints. For the same participant, empowerment was perceived as enabling a close working relationship with Healthwatch and Collaborative Thrive to ensure growth in their abilities to engage with the borough's diverse communities. Participant 2 summarised this by stating:

> *"We would look at what services we needed to commission and then we would tender out their services and then we would monitor those services to check that they met needs. What we realised was there were cuts coming in the system and we couldn't do the same with less money and felt that there could be better outcomes for people. So, we decided to adopt a complete bottom-up approach. We invited the observers or agencies like Healthwatch and Collaborative Thrive who sit on the board and brought in the service user perspective." (*Participant 2)

Three-quarters (N = 10) of the participants described how the local mental health trust, the CCG, and the local government established a new alliance contract that brought together two third-sector organisations, in response to the engagement with the service users, staff and communities.

> *"The framework of the Collaborative Alliance was formed in July 2018 and it is 7-10 years for the contract. This is an important change to yearly contracts or short contracts for a period of two to three years."* (Participant 12)

The participants described the transformation of the Collaborative Alliance as it grew from *The Collaborative.* This change shaped the collaborative outcomes and joint ventures have matured and been concentrated on achieving the desired objectives, empowering the service users and innovation in transforming care.

> *"It has been driving a major programme of service improvement and transformation across all key services, including community, placements and acute."* (Participant 6)

The importance of governance was confirmed by the participants and emphasis can be seen in the following four participants' accounts on how organisations are managed to encourage empowerment.

> *"The Collaborative Leadership Team (CLT), incorporates a user, caregiver and population's contribution, confirming governance and accountabilities for the Collaborative Alliance. Through engagement, people in the borough asked for mental health care designed around them."* (Participant 13)
>
> *"There was a historic culture of health and social care not working together, commissioning separately, not thinking about service users from the point of view of their needs. We are implementing policies to address inequalities by providing housing, volunteering and*

> *employment opportunities for service users, thus providing equal access to them in policymaking and organisation building through peer support."* (Participant 1)
>
> *"Front-line staff have the best ideas about how to improve care. They will be part of the decision-making along with the leadership, empowering the staff and promoting an inclusive staff culture."* (Participant 2)
>
> *"Mentoring is available and staff are given appropriate training to achieve the right skills."* (Participant 7)

The Council and CCG are committed to and empowered by the collaborative outcomes of *The Collaborative* and the performance framework, according to the participants. Together, they elaborated on these findings while establishing the Collaborative Alliance's overall approach, unified goals and anticipated outcomes. If the results in any field were not achieved, it would not have delivered the desired 'value' for the Alliance, the council or the CCG. As such, regardless of improved performance elsewhere, the Collaborative Alliance could not be regarded a total success. Participant 5 explained the responsibilities:

> "*The CLT is responsible for ensuring that the necessary evidence is gathered through procedures. All expenditures associated with data collecting, and service user, caregiver, and employee feedback, will be included in the Collaborative Alliance's budget.*" (Participant 5)

Participant 3 went further as she said:

> *"Before the introduction of the Collaborative Alliance, the processes through which the CLT monitored improvement against the objectives was agreed upon with the lead commissioner. Quarterly updates from the Collaborative Alliance bring the lead commissioner up to date on developments. Actual spend to date against budgeted spending, as well as performance in financial and non-financial results, will be detailed."* (Participant 3)

The participants confirmed that the performance outcomes were incorporated into the alliance agreement.

> *"The Council and the CCG have established an independent assessment board to validate threshold performance. Representatives of those utilising services and residents will be included. The panel will be supplied with an annual performance report, approved by the CLT, to suggest the payment of pain share/earnings to the commissioners."* (Participant 12)

The Collaborative also has a more official role in reviewing and commenting on performance reports from the Collaborative Alliance, providing formal feedback to the alliance leadership team and through the Council and CCG's governance mechanisms. Having the voluntary sector organisations being part of *The Collaborative* empowers the service users and the staff on the performance framework of the collaborative outcomes, facilitating improved outcomes for the service users.

According to the participants, 'The Evening Support' under *The Collaborative,* empowers the service users as they reported an average of a 2-point increase in how they felt before attending The Evening Support and after, on a scale of 1-10, when a questionnaire was used. To access this service, the service user needs a referral from a healthcare professional, such as a GP or care coordinator.

> *"The evening support is a free programme that provides 'secure places' for residents who are in a mental illness crisis and short-term care. It is available seven evenings a week between 6:00 pm and 2:00 am and provides relaxed, pleasant and listening space, a delicious dinner and activities, including painting, yoga, knitting and board games."* (Participant 9)

Once a recommendation is received, an evening support staff member will call the service user during opening hours. Psychiatric liaison teams can make referrals only in the local A and E, Home Treatment Team, CMHTs, Street Triage, Collaborative Access, NHS Trust, 24-hour mental health line or through GPs. Transportation can also be arranged to the service and back, if necessary.

Two participants, responding to the research question of the mental health provisions, expressed a positive reaction to the outcome as it provided an example of integrated care in the London borough.

> *"And we have supported people to get back in touch with family members that they haven't been in touch with for years to support them to build relationships differently. We have supported them with meeting people with shared interests in the community and not just using mental health services, using just the whole network of community services, and we have supported people to have confidence and belief in themselves."* (Participant 4)
>
> *"We are stepping them down from the highway of rehabilitation wards that were rehabilitating them to establish some of the skill sets that they have and building on that with the support from occupational therapists, psychologists and psychiatrists." (*Participant 11)

6.2.1.3.1 Policy

One of the government changes that the borough has implemented is Health and Wellbeing Boards. The boards aim to help give communities a greater say in understanding and addressing their local health and social care needs. They monitor budgets and performance and the new service initiatives and innovations, which was confirmed by Participant 12.

> "*We have a programme of work going into the future around how we are going to develop services from what the service users have told us, and to essentially it's where we can, as the board and in a governance sense, test the way integrated commissioning is working. Obviously, our alliance project, Integration Alliance, which was the next stage of The Collaborative and Collaborative Network, is where we can come together and discuss progress.*" (Participant 12)

Also, two key policy drivers that the participants reflected on were No Health Without Mental Health (2011) and The Five Year Forward View for Mental Health (2016), which set out several principles needed to implement improved mental health, including co-production with those with a mental health condition, collaborating with local government, commercial and voluntary and community organisations, and recognising needs and working with individuals proactively to prevent an acceleration in difficulties.

CT was introduced to lessen the disparities and injustices that Black people face in mental health care. They tackle the obstacles that contribute to lower results across a variety of social determinants, empowering and thriving service users.

Participant 6 shared the involvement of CT as

> "*We will take the community's issues into consideration, empower them to change and hold them responsible. We will promote Black leadership and incorporate members of the Black community in important decision structures, keep checking with the community if things work well, and adapt what we do as necessary.*" (Participant 6)

Local government and the NHS have different forms of commissioners, providers, third sector personnel, carers, community organisations, and local communities who have an active role in how mental health services are organised and delivered.

The Cooperative Council principles are concerned with trying to put residents first, trying to ensure that residents are able to develop their own solutions (Mirivel, 2015). When it comes to adopting a person-centred approach to health and social care, co-production is a suitable model to follow for local authorities intending to achieve health and social care integration.

> *"Co-operatives provide locally-owned and managed services working with community groups and find strength together in their expertise about the service through lived experience and commitment to co-production."* (Participant 13)

Participant 7, one of the founding members of *The Collaborative*, reflected, when asked about their roles and responsibilities within *The Collaborative*:

> *"Some of the people, both on the service user side but also on the clinician and provider side, who were most instrumental in making this change were people who are very much motivated by that new spirit of trying to do things differently that came through the coop council."* (Participant 7)

The local authority became the co-opted council, which enabled *The Collaborative* to engage with many external partners, whether it was on the design front or from policy bodies. Therefore, for Participant 3:

> *"Much of the time we are looking at this whole relationship between public services and local citizens. So, in terms of the difference, I suppose, what we have got established is the principle of collaboration across the whole system."* (Participant 3)

6.2.2 Theme 2 – Successes and Achievements

With the integrated agenda, many successes and achievements have emerged from the semi-structured interviews concerning *The Collaborative*. The provisions to address the socio-economic determinants of mental health, such as housing and support people on the pathway to work and addressing crime-related incidents are the three achievements.

6.2.2.1 Housing

One of the achievements of *The Collaborative* has been to provide appropriate housing for the service users, who needed support as well as help to live independently. According to the participants, the CH provides diverse services to help people living with mental ill-health access a range of support options quickly and seamlessly. Self-referrals can access specialist support from psychiatrists, occupational therapists and social workers, and also primary care provided by registered nurses. Staff from the housing provider support people with a range of social issues, including benefits, debts, housing, and social and community engagement. The aim is to intervene early, lowering the threshold for support and helping people to link into services within their community, reducing the use of secondary mental health services. This was reflected in one participant interview.

> *"We established community solutions, which are alternates to hospital admission. It resulted in a 60 percent decrease in hospital admission rates in the local authority. For patients who still require admission to hospital rehabilitation, we have been involved with the Rehabilitation Team to assist individuals to address their housing requirements more rapidly, to create friendships and community relationships, and to support individuals with personal budgets to help them rehabilitate."* (Participant 8)

The participants reflected that the underlying principles of the Integration Alliance, which delivers improved outcomes to people with complex mental health difficulties, aim to ensure that individuals have more personalised assistance possibilities in the community with bespoke assistance packages that fit their requirements, if feasible at home. The aim is to reduce hospital dependency and institutional treatment types. One important notion is that people should have the skills and resources to promote their rehabilitation, recognising as much autonomy as they can. Several different initiatives have been developed in the community services and the accommodation-based services to support moving people from restrictive settings into community settings. One of the participants described it as follows:

> *"Integration Alliance's objective is to reduce by 50 percent the usage of residential properties and encourage individuals to access housing where they can do more for themselves. Within Integration Alliance, there were some offers that supported people to achieve objectives of moving from restrictive settings."* (Participant 7)

An Integration Alliance Panel and Integration Alliance Advice Surgery have also been set up. Staff from Collaborative Commission and the council can benefit from these surgeries. The rehabilitation team can advise on how patients with a more tailored offer might be supported to avoid having to offer hospital or residential services. There are several housing alternatives for people who are living in their own houses and who require significant assistance.

> *"So, for example, the housing provider managed to get some finance and they bought 13 flats on the open market through private investors. If you look at all of our housing at the moment, one of our key issues is that we are just blocked up. We have got 63 people who can move if they were independent flats, but in the borough, there is nowhere. With the housing provider, this might be something other areas want to do in the future."* (Participant 12)

According to participant 12, who is the head of a community recovery programme, which is utilised as a step down from rehabilitation wards and as an alternate option to inpatient care.

Participant 11 expressed how the housing directory benefits the staff and service users equally to identify the best option to suit their needs.

> *"We acknowledge that keeping up with all of the housing alternatives available, both those with mental health problems and those offered via the council, has been difficult for staff; therefore, we have created a housing directory."* (Participant 11)

When discussing the specific barriers and facilitators for *The Collaborative* in achieving the collaborative outcomes, more than three-quarters (N = 11) of the participants spoke about supporting people in their own homes to recover and stay well, which is one of the collaborative outcomes.

Participants mentioned that the Collaborative Options Team is a service provided by *The Collaborative* that the participants felt had an impact in providing the community mental health services.

> "*The collaborative options team included the development of a Rehabilitation Team, a multidisciplinary team of non-profit organisation employees, caseworkers, nurses, occupational therapists, and consultant psychiatrists, working to actively assist people in their homes who might otherwise have been in inpatient care. A medication management service was developed by working with Look Ahead, a voluntary sector provider.*" (Participant 1)

Participant 7 suggested that this programme assisted people in learning about their medications and in taking them at home, up to twice a day, seven days a week, rather than having to transfer them to a more supportive setting.

> *"So, we initially delivered a service called the collaborative options team which was an early attempt to look at how we could provide the social support to enable people, for example, to step down from secondary care and be supported by their GPs. People's mental health is very much influenced by what is going on in their lives. Clinicians can have less time to respond to peoples' social problems. Being able to respond to those social problems can make a real impulsive impact on their mental health."* (Participant 7)

Participant 6 confirmed the number of people, who were being supported.

> *"We are now getting 500 people a month asking for help."* (Participant 6)

Team effort was emphasised.

> *"Service users were not allocated to specific individuals; rather, they were assigned to a team, with each member bringing a unique skill set. While individuals developed personal ties with patients, the open caseload as a team commitment, worked effectively."* (Participant 11)

6.2.2.2 Education, Training, Volunteering or Employment

It is critical to assist those who have been rehabilitated or who are rehabilitating from mental illness in finding and keeping meaningful work. The interviews revealed this as one of the achievements and that *The Collaborative* has recognised. The employment experts have been trained to work with people who have mental health issues, and they focus on helping people find and maintain employment using a person-centric approach (Burwell and Chen, 2006), ensuring that their job is appropriate for them. Other help includes the development of interview skills to prepare and manage employment, training, and maintaining health, using a targeted and holistic support model.

One-quarter (N = 3) of the participants noted that 633 members had attended Collaborative House over the year a total of 23,347 times; this was an average of 79 members attending each day. They reflected that there was more to do to support people with mental health conditions moving back into employment and education within *The Collaborative*, and implementing the mental health employment strategy to offer a new collaborative approach to providing training and employment opportunities was one of the top priorities for CH.

Participant 10, one of the directors, reflected,

> "*We are making an important contribution in supporting people who are living with a mental health condition and this borough has a wide range of volunteering and mentorship opportunities, accessibility to education and work, access to assistance during times of crisis, and support in obtaining the information and signposting to relevant partners.*"

Three quarter (N = 10) of the participants stated that the Employment, Education and Information Unit (E, E and I) in Collaborative House has collaborative relationships with multiple stakeholders, such as Jobcentre Plus and the Department of Work and Pension, and that care seekers could develop skills, such as creating Curriculum Vitae (CV) and planning for interviews, advertising and marketing, research, planning and conducting workshops, running information technology workshops and website upgrades, peer assistance, inputting data, completing administrative tasks, structuring and designing activities, and running communications and marketing presentations.

One participant described the provision as inspirational.

> *"It is good that employment is a big factor in mental health provision within The Collaborative. We are so proud of playing the part in Collaborative House. Every member is entitled to do what we call the transitional employment placement here, which is a part-time role normally for six months, but it is a proper job with a proper employer paying at the market rate."*(Participant 8)

Another project shared was the Black Men's Minds Project, a six-day course designed in collaboration with CT for Black men who have struggled with mental illness. Every day, unique themes are being explored, such as the pressures a Black man faces from the outside world, developing skills, masculinity, and life experiences.

> *"A lot of them support and help other people, use that as a means to move on and experience the feeling of pride and independence and confidence that comes with working. At the same time, it reduces their dependence on benefits and helps them to progress so much better."* (Participant 3)

One participant described their strategic leadership.

> "*What I have done in the last two years is to build relationships with the strong employment providers, who include really good social enterprises. We are cross-referencing members and we want to diversify the range of employment placements that we can do for people because, with the mental health landscape of the borough, a lot of the employment placements that we provide for our members are in mental health settings.*" (Participant 7)

Education is essential to increase the opportunities to get a job and it has been recognised by *The Collaborative,* according to the interview data. Collaborative House works with the local colleges to provide training and educational provisions.

> *"The courses which are delivered here are the first step for the members, who have anxiety issues and confidence issues. Service users will learn the skills, tactics, and information they'll need to manage their own rehabilitation. This allows individuals to have happier, healthier lifestyles, requiring less extensive crisis intervention."* (Participant 4)

Part of the collaborative outcomes and one of the aims of Integration Alliance includes increasing the number of individuals employed, volunteering, or enrolled for education or training, and this was reflected in Participant 10's comments.

> *"People have been able to reclaim their identities and experience a sense of belonging in their communities. We have promoted peer support inside the programmes, worked with families to repair damaged ties, and encouraged volunteerism."* (Participant 10)

6.2.2.3 Criminal Justice

Many participants reinforced the importance of other partnerships, such as Healthwatch and CT, in influencing the service users regarding the criminal justice system, which is another success of *The Collaborative,* according to the participants.

> *"The Collaborative Commission is up for the partnership and we have become the place where people who provide, use and commission mental health services meet with the police and the community and that, in itself, for us, has been a step forward. I don't think other health watches in London have that relationship. Even if you sit on the adult safeguarding board with the police, we were working together to stop the tension, to stop restraint, to direct people in need to proper therapeutic services rather than a police cell."* (Participant 9)

The coroner produced a report on the death of Michael Payne (name anonymised) in 2008 and the disproportionate relationship between people from Black African or Caribbean backgrounds and psychiatric detention. The Health and Wellbeing Board of the borough, in 2013, initiated the establishment of an ethnic commission to examine better mental health preventative measures and therapy for the Black community. Many recommendations were drawn up and incorporated into the partnership working of *The Collaborative* and Collaborative Alliance. In 2014, the health and social services in the borough combined forces and launched CT to help people living with mental health conditions.

One participant recalled:

> *"In 2008, a black male, who was in the care of the Collaborative Commission, died in police custody in the police station in the borough. With this incident, the system of 'zoning' utilised by the Community Forensic Service was reinforced. This governs the treatment of specific patients by the clinical team. The community forensic team is now visited every day, face-to-face, by patients in the red zone where there are worries over the likelihood of recurrence."* (Participant 10)

According to the 2011 'Count Me In' census, Black people are 40 percent more likely than White men to obtain mental health assistance through the criminal justice system. The successes and achievements of *The Collaborative* show how integrated working has improved the outcomes for people with mental health conditions in the London borough.

6.2.3 Theme 3 – Challenges

This research has also identified challenges that prevent the population from being diagnosed and getting treatment in mental health services. Substantial disparities which exist when accessing mental health services by the black and minority ethnic (BME) community are the first barrier. Socio-economic factors also affect the incidence and presentation of mental health problems and access to assistance and resources in the London borough, according to the participants. This has resulted in *The Collaborative* trying to implement flexible initiatives to provide services to shifting demographics and ethnic groupings and people facing socio-economic issues.

6.2.3.1 Ethnic Disparity

Ethnic disparity was the first sub-theme derived from the interviews under the challenges as there are a wide range of different barriers for BME populations to access mental health services. All the participants talked about the importance of *The Collaborative* in creating opportunities to develop initiatives that would eradicate ethnic disparities for BAME communities.

Participant 1 explored these issues in some depth and asserted that:

> *"The Black population is susceptible to having serious mental illnesses disproportionately. In the borough, people from Black communities have double the risk of severe mental illness, compared to their White British equivalent, and are more likely to be sectioned under the Mental Health Act."* (Participant 1)

The participants also shared how those from a Black Caribbean ancestry remain the largest group of Black people impacted in the borough in terms of numbers.

One Participant shared:

"The borough has been home to the UK's largest Black community since the arrival of the Windrush generation in the 1950s. Many people of African and Caribbean descent have prospered in this country and contributed significantly to our socio-economic life. Despite the achievements, inequalities persist, particularly among persons of Caribbean origin, and this imbalance is most visible in mental health and wellbeing." (Participant 2)

Black people in the borough are twice as likely to have severe mental illness compared with White British people (NHS Digital, 2018). In 2018, while there were 1900 people, or 1.4 percent, from Black backgrounds known to have SMI, the White British background people with SMI equated to 1370, which is 1.4 percent.

Another participant shared what triggered the importance of improving Black African and Caribbean residents' mental health issues, as referred to during the criminal justice session.

> *"In October 2012, the Health and Adult Services Scrutiny Committee (HASCC) of the local authority was tasked with scrutinising the coroner's findings on the death of Michael Payne - a local, black man, who had mental health conditions and who died in police custody in 2008 - finished its investigation. The committee was able to draw upon information provided by Payne's sister and the commissioner, who supported the case that the borough must do more to tackle Black African and Caribbean citizens' comparatively low mental health and wellbeing."* (Participant 5)

Such data and the coroner's report on Michael Payne's (name anonymised) death in 2008 led to the newly established Health and Wellbeing Board of the borough to set up the Ethnic Commission in 2014 to promote mental disorder prevention and the care of Black people. The commission heard that a person's mental health was just one component of the victim's existence. The committee spoke with a researcher whose study had focused on African-Caribbean connections and mental health. He felt that transforming services of mental health should be linked with altering the position of the Black and other ethnic minorities overall. Most of the racism and discrimination faced by Black people, whose origin was from Africa and the Caribbean, had a historical background and reflected fundamental inequities within communities.

> *"The Commission's goal is to see how our Black residents are improving regarding mental health prevention and treatment. The Commission's first proposal is that the local authority continues to create a collaborative approach with citizens, in order to assist each other and empower each other to improve their health and wellbeing. This should be supported by a long-term, integrated strategy to endure the greatest possible use of resources in strengthening a way of life that supports individuals from conception to the end of their lives."* (Participant 3)

This aligns with the collaborative outcomes and the research aim for integrated care. Most participants acknowledged the contribution of CT, which works together in mental health services to decrease inequality and discrimination among black people. CT is an alliance with the community, statutory, voluntary and private sector partners, and which belongs to the research borough. They address the barriers Black individuals from Africa and the Caribbean face, all of which can adversely affect the health and wellbeing of the individual, leading to poorer outcomes regarding several social aspects, such as education, work, accommodation, and so on.

> *"Black people in the borough endure poorer mental health and welfare results than their White British counterparts. A shared measurement system will be used by the collaboration to communicate its progress. Together with a number of statutory organisations, including The Collaborative, and members of the community, the public health team and facilitation team*

> *of the borough have developed a set of indicators that are based on the work of the Ethnic Commission (2014).”* (Participant 2)
>
> *“One of the criticisms of The Collaborative was it didn't particularly focus on the needs of BAME service users, so I think that's one of the areas we are trying to focus on to make sure the alliance does.”* (Participant 11)

This is the driving force behind the Collaborative Alliance, according to Participant 11. The CT team continues to work closely with *The Collaborative* and Collaborative Alliance. The collaborative outcomes show that black people make their own choices about treatment, care and opportunities to express and plan for their life goals, and the improved mental and physical health for those in mental distress seeking improved recovery. Also, it aims to ensure that Black people in mental distress have access to the entire spectrum of suitable treatment and care, and that Black people in mental distress are understood, accepted and well supported by staff. In addition, the staff are fully capable and confident to work well with the Black populations, i.e., services are free from discrimination and culturally competent. The collaborative outcomes also include increased ability to participate in society and life, in general, on an equal footing with others, e.g., being free from discrimination in education/employment, having opportunities to make friends or have a family life, have access to housing and community involvement.

Participant 3 emphasised that engagement with the community and the voluntary sector remains strong.

> *“In order to provide information on the disparities that Black communities in the London borough suffer across a variety of statutory services, Collaborative Thrive organised an event in February 2019 in collaboration with a charity. More over 100 people came and spoke with system officials about their personal experiences and suggestions for reform. This offered a key framework for the partnership's work, highlighting areas that need more research as well as where systemic change is needed.”* (Participant 3)
>
> *“Commissioning mental health services in the borough faces substantial obstacles, including high demand for services, a lack of cohesion across organisations, funding constraints, and healthcare inequities. The system must continue to grow and evolve in order to address these issues and enhance the experience and results for patients of mental health services in the borough. The Collaborative Alliance, a one-of-a-kind cooperation of commissioners and providers, is experimenting with outcome-based contracting for mental health care.”* (Participant 5)

A draft equalities impact assessment was completed as part of the changes within the Collaborative Alliance and a large share of the Black population took part, especially African and Black Caribbean people who have a higher entry rate according to Mental Health Act assessments. The Collaborative

Alliance work very closely with CT to think about how the outcomes, referred to in the interview and focus group guide in the appendices, are measured for that population, how to consider providing services or outreach to communities and how the system should change in response to people's needs. There are poor outcomes for Black people in the mental health services, with a particular focus on Black men in the forensic part of the system.

One commissioner shared statistics,

> "*Compared to White British people, Black people were twice as likely to be detained by the police and sent to a secure site for evaluation under section 136 of the Mental Health Act. White British citizens were five times less likely than Black British citizens to be subject to a warrant under section 135 of the Mental Health Act. This data pertains to a snapshot of 2018's first nine months. Compared to White British service users, more Black patients in the borough's psychiatric hospitals are physically restrained. The Collaborative Hub is used and accessed by Black people more than White people.*" (Participant 11)

Another participant reiterated the usage of CH as:

> *"You could say that's good because part of the challenge for BME populations is late presentation, whereas this would have a say in it because the whole point about the hub was to try and get people much easier access to the service. You don't have to go the referral route. You can just walk in. So, twice as many Black people are using the network hubs than White people."* (Participant 6)

6.2.3.2 Financial Constraints

The cost of keeping people in hospital has a huge impact on the budget, according to all the participants. There is a major challenge for the hospitals about people using Accident and Emergency in a mental health crisis, utilising up to £10 million each year in terms of medical care and resources. As a result, there has been a debate about developing a new professional workforce for peer support and deploying them in the Accident and Emergency departments to assist people in distress. The suggestion is to place peer workers at every Accident and Emergency department, and it was proposed that this should be a long-term endeavour rather than a one-time effort with unstable financing. This practice is called peer in-reach into acute wards and there is currently a pilot with five wards accepting employed peer supporters on hospital wards.

Participants shared how beneficial it was for getting patients out of the wards and helping them in engaging with the community and doing ordinary activities like sharing meals and socialising at Collaborative House:

> "*It has created a refreshing change in atmosphere, and it is important to have the activity's consistency, as it occurs every day for three hours.*" (Participant 1)

The budget and savings are major factors in the transformation, as Participant 5 stated:

> *"The overall financing for 2018/19 was estimated to be between £62 million and £65 million. This is based on the 2017/18 service contracts, with a 3 percent annual savings rate and a population and tariff boost for the NHS component. A considerable shift in investment patterns will occur in favour of providing preventative and early intervention support. By simplifying teams, shifting resources to prevention and early intervention, and focusing on minimising hospitalisation, significant cost savings can be achieved."* (Participant 5)

The Collaborative Alliance funding, as stated under the Empowerment section of this chapter, comprises the bulk of the Council and CCG mental health expenditures for working-aged people, which totalled roughly £66.1 million in 2017/18. The participants explained that this sum was made up of about £9.5 million in council budgets and £56.6 million in CCG funds for the 2018/19 fiscal year. These budgets included costs for contracts only and did not include any staffing across the CCG and Council. The projected total budget for the Collaborative Alliance over seven years is calculated to be £458 million, and 652 million over 10 years (including the optional three year extension).

Participant 13 shared:

> *"Over the first seven years of the Collaborative Alliance contract, the Council and CCG must save around 14 percent in efficiency. The alliance contracting model is projected to give a credible potential to fulfil the financial and operational challenge while also improving people's lives."*

Participant 10 also raised concerns on the budget

> *"Approximately £17.7 million in savings will be required over the next seven years to address anticipated demand growth, increased investment in mental health services in accordance with national needs, and government-mandated efficiency."*

Participant 6 stated that:

> *"There are lots of other groups, such as finance leads, quality performance groups, a communications group and engagement group. I spent two-thirds of my time doing reports and presentations to these groups. That shows how much data I am sharing and the amount of time I am spending when there are resource issues and financial pressures."* (Participant 6)

Participant 10 confirmed that the Collaborative Alliance contract identified savings even though it was required to manage delivery of the Mental Health Investment Standard (MHIS), the Mental Health Five Year Forward View, and mainstream services.

> *"In the first year, it has delivered around £2.6m of savings and efficiencies for reinvestment in the borough mental health services."* (Participant 10)

6.2.3.3 Stigma

From the participants, another factor that affected males with mental illnesses more than women was a reluctance to admit they were having problems and to seek treatment. The causes were numerous, yet they could all be condensed into one factor: stigma. It is undeniable that stigma has a harmful impact on people who suffer from mental health problems. It results in the mentally ill resisting seeking therapy because they are afraid of being identified and, as a result, rejected by society (Shrivastava, Bureau and Johnston, 2012).

Participant 9 confirms the issue:

> "*The irony is that therapy is accessible and may be extremely beneficial, but shame and embarrassment restrict men from talking about their problems. We at The Collaborative are working with the Collaborative Thrive to address the issue*."

According to the 2014 Time to Change viewpoint survey, a frightening 93 percent of the Black and Minority Ethnic (BME) population that suffer from mental health difficulties are faced with stigmatisation and discrimination because they encounter a harmful blend of prejudice against individuals because of their race and their mental health.

Through integrated care, *The Collaborative* is trying to eradicate mental health stigma for men and to respond to the research question: *How has The Collaborative facilitated the integrated care process for mental health outcomes in one London Borough?*

Addressing broader issues such as relationships and stigma confirms that some communities are reluctant, for a variety of reasons, to access some services. Participant 12 stated:

> *"The key challenges around the collaborative outcomes are that a number of the outcomes rely on, for example, access to housing, support to work or vocational support, and we will try the input of others. There is an issue about what influence you have over the work of housing or what is now the Department of Work and Pension (DWP) or indeed what other providers are doing. So, a lot of it was about influencing the Black and minority communities to access the service even though stigma was preventing them from using them."* (Participant 12)

Participant 2 summed up the stigma in the community as:

> *"So, we're never going to have good mental health unless we address issues such as access to housing and supporting people on the pathway to work, maximising people's income. Also, addressing broader things such as relationships and linked to that is addressing issues such as stigma, to know that the Black communities are reluctant, for a variety of reasons, to access the mental health services."* (Participant 2)

6.3 Chapter Summary

This chapter has highlighted the importance of collaboration or partnership for the senior leadership team of *The Collaborative* in providing mental health provisions for the service users. The participants of the semi-structured interviews have identified underpinning principles, successes and achievements and challenges, which contribute towards achieving the mental health outcomes. *The Collaborative* has set up many linked service developments with an emphasis on peer support; it represents people early on, builds on their assets and strengthens their communities. These provisions are easily accessible in the communities. *The Collaborative* has the underpinning principle of empowerment to achieve the best outcomes for the service users, achieved by employing governance, alliance contracting, national policies and performance frameworks.

The participants were eager to share the successes and achievements and these included services that enabled the essential stakeholders to initiate a mental health debate encompassing everyone in the borough's system, from those commissioning and delivering services to those receiving them, to effect change for service users. The services helped to initiate the debate through feedback, engagement sessions and *The Collaborative* breakfast meetings. According to the participants, one of the guiding concepts has been that everyone's perspective and involvement were equally significant, which has proven critical in fostering lively debate and the development of new ideas and methods. The achievements included access to housing; education, training, volunteering or employment; and action on the criminal justice system.

The senior leaders also explored the barriers to community discussions on mental health, which may dissuade some individuals from getting treatment. Multiple factors contribute to poor mental health outcomes in BAME communities, including lack of access to elevated mental health services, the sociocultural stigma around mental health treatment, discrimination, and a general lack of understanding about mental health. Another barrier explored was the financial constraints and the cost of keeping people in hospital. However, the majority of the interviewees responded by saying that they embraced the intervention of *The Collaborative* in addressing the barriers and making mental health provisions available for the service users and the population.

CHAPTER 7: FOCUS GROUPS FINDINGS

7.1 Introduction

Understanding integrated working and how it impacts the mental health outcomes of the residents in one London borough is central to this thesis. As has been highlighted by the literature review (Chapter 3), the voices of the front line staff have largely been ignored within the mental health research landscape. This chapter contributes to covering this gap with an analysis of focus group discussions with front line staff representing the different services within *The Collaborative* in relation to outcomes, thereby setting the scene and providing the context for service user mental health outcomes.

This chapter is the last of the three analysis and findings chapters and synthesises data from the five focus groups which took place during the case study research. It will also examine in detail the themes derived from the data. The analysis of the data from the front line staff is presented in relation to the existing literature on exploring initiatives to improve mental health outcomes of service users.

Five focus groups were conducted with a total of 20 operational level staff and front line staff of the four services. These provide information on the improvements in the mental health services in the London borough under study. The five groups are coded as FG1 to FG5 and the 20 participants are coded as p1 to p20 to assure anonymity.

The four services were:

- Integrated Alliance

- Collaborative Centre

- Collaborative House and

- Peer Support Network

The demographic information of the participants is shown in Table 7.1.

Table 7.1 Focus Groups Participants

Focus Group 1		**Focus Group 2**	
Number of participants	4	Number of participants	4
Position	Lead Support worker, Practitioner, Senior Practitioner, Support Worker	Position	Peer Support Worker, Deputy Manager, Manager, Peer Support Worker
Gender	3 Female, 1 Male	Gender	2 Female, 2 Male
Number of years with *The Collaborative* (1-5 years)	1	Number of years with *The Collaborative* (1-5 years)	2
Number of years with *The Collaborative* (6 - 10 years)	3	Number of years with *The Collaborative* (6 - 10 years)	2
Focus Group 3		**Focus Group 4**	
Number of participants	4	Number of participants	4
Position	Lead Mental Health Support Worker, Mental Health Support Worker, Lead, Support worker, Practitioner.	Position	Lead Peer Support worker, Manager, Senior Practitioner, Mental Health Support Worker.
Gender	2 Female, 2 Male	Gender	3 Female, 1 Male
Number of years with *The Collaborative* (1-5 years)	3	Number of years with *The Collaborative* (1-5 years)	1

Number of years with *The Collaborative* (6 - 10 years)	1	Number of years with *The Collaborative* (6 - 10 years)	3
Focus Group 5			
Number of participants	4		
Position	Care Coordinator/Mental Health Nurse, Psychiatric Nurse, Lead Psychiatric Nurse.		
Gender	2 Female, 2 Male		
Number of years with *The Collaborative* (1-5 years)	2		
Number of years with *The Collaborative* (6 - 10 years)	2		

7.2 Focus Group Findings Themes

Similar to the semi-structured interviews, the thematic analysis of focus groups data identified three main themes: Underpinning Principles, Successes and Achievements, and Challenges. Three sub-themes were derived from Underpinning Principles, these being Collaboration, Peer Support and Empowerment. Collaboration involved multidisciplinary team working and Empowerment involved the voluntary sector organisations (Figure 7.1). The sub-themes of Person-Centred Care and Outcome-Based Care; Housing, and Education, Training, Volunteering or Employment (Figure 7.2) were derived from Successes and Achievements. The third theme of Challenges yielded the sub-themes of Financial Constraints, Differences in Staff Culture, COVID-19 and Stigma (Figure 7.3). All the three themes and the sub-themes contribute to answering the question: *How has The Collaborative facilitated the integrated care process for mental health outcomes in one London Borough?*

Figure 7.1 Focus Groups Theme 1

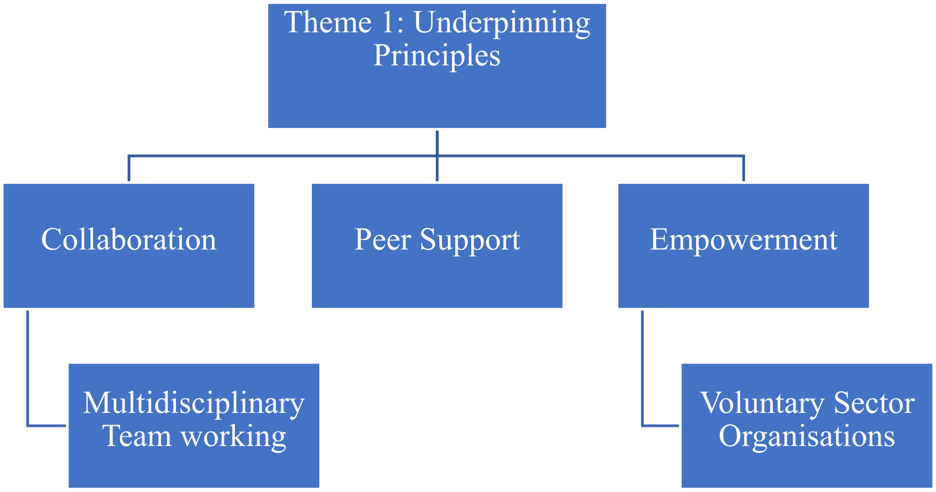


Figure 7.2 Focus Groups Theme 2

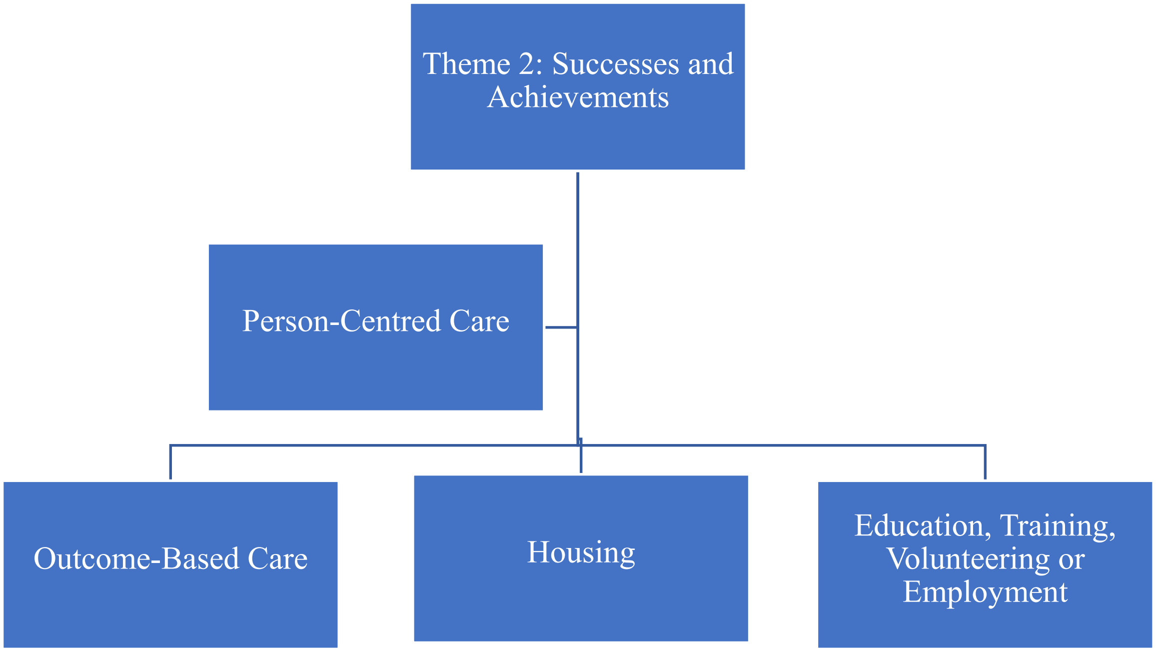
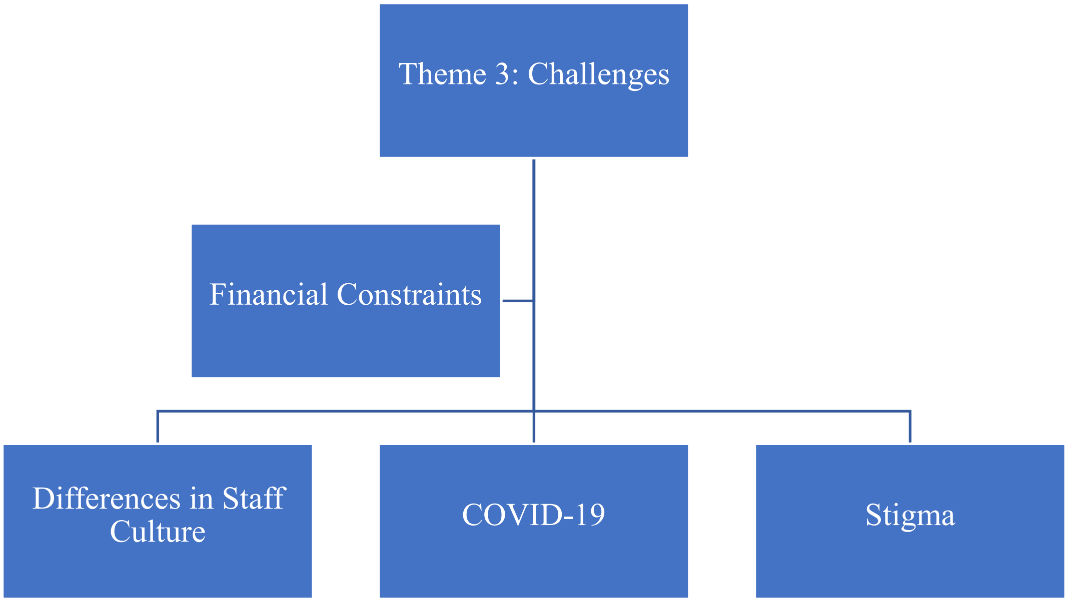


Figure 7.3 Focus Groups Theme 3



7.2.1 Theme 1: Underpinning Principles

The discussions within the focus groups comprising front line staff of *The Collaborative* revealed three principles that formed a foundation for support of the provision of mental health services. Theme 1 and its sub-themes were the same as the semi-structured interview themes. The following principles, which draw on findings from the research, underpin the process through which a group of organisations constructively explore their ideas and power to look for a way out that is far more extended than an individual's limited vision. The process gives and receives encouragement and assistance to achieve long-term recovery and the degree of power, influence, and the options that mental health service users have over incidents that have happened in their lives. These principles underpin the mental health services and the development of policy options and the strategy for their delivery. They will be relevant to various degrees based on the organisation's processes and the level of their engagement, as well as service user in question.

7.2.1.1 Collaboration

Exploring the research question *How has The Collaborative facilitated the integrated care process for mental health outcomes in one London Borough?* with the front line staff of *The Collaborative* has revealed Collaboration as one of the sub-themes of the underpinning principles.

All participants emphasised that their engagement with the voluntary and community sector (VCS) and the statutory sector was focused on integrated patient-centred health and care models. For the clinical front line staff who did not have experience in integrated care before joining *The Collaborative*, the system was perceived as providing substantial benefits.

> *"It's great that we have the voluntary sector because it offers a different perspective to care, and I can see the differences with the voluntary sector involved now. For me, it is those factors such as resources, staffing and not being restricted within our roles."* (FG5, p18)

For some, the outcomes emphasised that in an ever-changing healthcare ecosystem, the VCS can provide both agility and stability. VCS organisations frequently have strong foundations in the communities in which they operate. Since they are part of society, they can link local assets and be sensitive to local needs, resulting in stronger connections and trust within their local communities.

According to all the front-line staff, the partnership working model had a positive impact on the service user, the practice and the workforce. For example, the patient experience was enhanced, as was the treatment and administration of their mental health services. There was more consistency in care, a better patient experience, and fewer visits to A and E and the hospital for the same problem. While discussing partnership working, one participant asserted that the drop-in session once a week brought together the staff with the service users.

> *"We would do assessments and one of the things I loved about that was the interaction with the clinical staff and the clients; it felt very dynamic. It felt very kind of community involved. I would be meeting people in community clubs and, actually, some of the drop-ins were also facilitated by a couple of former service users. So it is very collaborative."* (FG3, p9)

The London borough under study desired a new system that could change investment from secondary to primary and community care to help individuals obtain treatment, to concentrate on people's knowledge and resources, and to combine clinical and medical services with social offerings that addressed the broader causes of ill-health. According to one participant:

> "*The Collaborative has fostered co-production in the process of transformation and encouraged professionals, service users and carers to work with one another and not against one another.*" (FG3, p10)

The multidisciplinary team participating in the care of a service user communicated directly with the team of professionals, thereby improving interprofessional communication and accelerating decisions. The focus group discussions explored the current services and assistance in the way they were offered and how they affected the lives of people. This featured innovation, obstacles and ongoing improvements that were made in cooperation with the service users and their caregivers. The front-line employees reported the development of open, co-productive relationships with those who needed the services, the commissioners, the local authorities, health and social care trusts, care managers and the community. *The Collaborative* also benefitted by agreeing on specific, quantifiable goals for monitoring operational efficiency and identifying opportunities for improvement. The following quotes provide examples of the commitment of the participants to providing holistic, person-centred services and care.

> *"Our priority is providing holistic and recovery focus. We work with patients and we take on their views from the beginning by completing a thorough initial assessment with patients to the care planning to ensure that they do express their choices for their treatment."* (FG4, p15)
>
> *"It is patient-led, and that is key. It is within the statutory and voluntary sector resources that we have, to set the short term and medium-term recovery goals. In a nutshell, trying to formulate the care plan jointly in collaboration with the patient to try and make sure that we have a framework to work towards."* (FG5, p19)

7.2.1.1.1 Multidisciplinary Team Working

For some participants, working in the multidisciplinary team, one of the themes derived from the sub-theme Collaboration, helped speed up a lot of the processes and minimised the bureaucracy. This quote was from a discussion about the steps taken to ensure that collaborative outcomes were achieved:

> "*People were stuck on the wards, quite a lot of money was spent and, more importantly, they were stuck there with no future. Rehabilitation Teams support those people who don't need to be in the hospital and that was how the RT team has grown. The RT team was the first multidisciplinary team in The Collaborative. The RT team has been very successful in business, bringing all the different professionals together and that has been really beneficial for the clients, also.*" (FG2, p6)

The Collaborative Centre structure provides the integrated working environment, having swift access to clinical nurses, psychiatric nurses and the support workers in the same building. In addition, it involves people from different backgrounds and different demographics. With this structure, there is easy access to other services in the Collaborative Commissioner and learning from these services has enabled the staff to better support the clients.

> *"We are able to get their input on our clients quite quickly as opposed to having to write an email and send it to someone in another part of the borough and having to wait ages for*

> *feedback. The feedback I have had from doing joint visits with doctors was that they appreciate the non-clinical communication that we have and our approach with patients."* (FG2, p6)
>
> *"I do feel like my knowledge of other services and the social care team and different agencies who we work with closely has improved as a result of knowing more people from these teams and having more connection to them."* (FG2, p8)

7.2.1.2 Peer Support

Peer support is also a sub-theme under the Underpinning Principles theme in both the semi-structured interviews and the focus groups and, evidently, it plays an important role in *The Collaborative*. The main aim is to offer lower-level intervention when the service users do not require intense therapeutical counselling. There is a very long waiting list for peer supporters. The participants confirmed that the demand for peer support was high and there was a very long waiting list for the interchange between persons who identify as peers on the basis of mutual and comparable experiences of mental illness and of emotional and practical assistance.

The crisis line was an example of peer support provision that was discussed. It is the only London borough (during the study - December 2020) offering this service. The voluntary sector staff suggested that what the clients needed was 20 to 30 minutes to get through their acute crisis and they felt better and more able to cope as a result. In three of the focus groups, the participants suggested that the crisis line dealt with the acute stages of crisis, whereas the community service dealt with what happens the day after and a week after that crisis has presented itself.

> *"From our perspective, I see us as helping individuals on a lower intervention. And that is basic emotional support, sharing experiences and narratives and being able to guide someone towards appropriate statutory and voluntary services, if need be, to assist them."* (FG3, p11)

One service that the voluntary sector staff provide is the crisis plan goal trackers, and the participants shared how it benefits the service users.

> *"When the clients approach the service due to self-harm or they have issues with family, friends, loved ones, the crisis line is designed for the individuals to be self-reliant. Even when they can't get hold of the staff, they can be referred to the crisis plan to think about what they can do for themselves."* (FG2, p7)

The crisis plan is designed to ask simple questions like: What is the problem? How did you cope last time? What did you do to help yourself? What are the triggers?

> *"Little questions like that can make someone sit down by themselves and think about it."* (FG4, p14)

> *"In the goal tracker, if the individual achieves something, they can tick a box, just like a bucket list where they can track themselves. The staff don't have access to that and it is strictly with the person. This has resulted in an increase in autonomy."* (FG4, p13)

One participant in Focus Group 1 shared a practical example of how the Integration Alliance service user involvement group and buddying networks continue to support the service users.

> *"I was speaking with a service user and she was panicking and her emotions were all over the place. I had to act and I asked what she would do usually when these things happen to them and what are her coping skills. She said that she couldn't remember. She usually didn't do anything. So, I started asking what about music or going for a walk. She went for a walk and came back and listened to music. She called me back and said, 'Thank you so much. That really works.' Next time, she will apply that. So that is a practical example."* (FG1, p2)

The peer support workers from all the services collect qualitative feedback (sometimes in video form) after obtaining consent from the service users concerning how any service they received had impacted them. That feedback was shared with the commissioners and the other partners of the services.

One of the participants, who is also a service user with lived experience, said:

> *"My organisation has really appreciated my role because I have been there as a representative of the service user and there to represent the patients' views in multidisciplinary meetings. I was able to see a different aspect to clients' opinions and clients' illness that other clinicians probably didn't have. I have seen improvement in some of my clients' health because of my disclosure and validating them with the experience."* (FG3, p10)

7.2.1.3 Empowerment

This principle was evident from the focus group discussions with the front-line staff in which many participants reported the individual, organisational, service-user and societal level of empowerment.

For *The Collaborative* to empower, the knowledge, skills and experience of the service users working in co-production required to improve access and outcomes was evident in the discussion. The crisis plan's goal tracker, referred to in the peer support section, enables the service user to have belief in themselves, to manage and influence their own lives, and to gauge the impact they can have on their lives. Also, the Integration Alliance service user involvement group and buddying networks, noted in the peer support section, shows the organisational/professional level of empowerment, which is evidence of the treatment of the individual with mental illness by the network and the specialists. In this case, empowerment addresses how care staff want to empower themselves to serve service users.

One participant believed that her readiness to communicate improved the mental health of the service user:

> *"I had a client in The Collaborative flat with quite low moods due to issues that he was having with the change of his medication. He was having lack of sleep. He wanted to go for a coffee and to talk about his issues and at the end of the conversation, he was willing to make his own choices and decisions."* (FG3, p12)

According to another participant

> *"If it wasn't there they would be lost because they really appreciate what we do, and especially when you see them come one way or you approach them in one state and the conversation ends up making them feel better and going away stronger. It is life-changing for us, the front-line staff and the service user. So, it is very, very important that these services are there."* (FG4, p14)

The service-user level of empowerment is evident from the feedback reported in the next section, Voluntary sector organisations, concerning drop-in services facilitated by the service users and their participation in *The Collaborative* breakfast meetings:

> *"Inviting service users to engage with, and support user-leading initiatives extends beyond the care plan into participation in the management and development of services and policies."* (FG1, p1)

One participant was a service user when introduced to *The Collaborative*.

> *"We are looking at the improvements and how they move forward. It is usually really positive because of the ethos of The Collaborative's standards and the way that it operates. My transformation from a service user to an employee is an example. Through that interaction, coming to the Evening Support instead of going to hospital, or feeling worse, being at home in isolation, the improvements are quite pronounced and they go from feeling terrible to going into day service."* (FG2, p7)

7.2.1.3.1 Voluntary Sector Organisations

Participants talked about how voluntary sector organisations have empowered the service users, working in an integrated way to innovate and increase the chances of mental health outcomes improvement and, therefore, this is a sub-theme of the underpinning principle of Empowerment. The participants' beliefs in *The Collaborative*'s services are demonstrated as:

> "*We understand that many services in the borough are trying to improve the mental health of the people but being under The Collaborative means that everyone knows what other services are doing and tries not to duplicate them.*" (FG3, p9)

> *"We are fighting for one thing, which is improving mental health. This collaborative is fierce due to the role of the voluntary sector."* (FG4, p14)

Some of the participants said that support workers from the voluntary sector experienced the best part of the job as they could make invaluable contributions for the clients' benefits.

> *"It is all about just having simple conversations with them, not about medication, not about seeing psychiatrists, not about seeing doctors and nurses."* (FG4, p16)
>
> *"Pre-COVID, we were able to take them out in the community to do shopping with them and whatever they wanted us to do. Clients always value that. The psychiatric nurses don't have the time to do that. We, as voluntary sector organisations, are still working well in that way. But the paperwork that goes with it sometimes overtakes the priority."* (FG2, p8)

As the participants shared, to the best of the author's knowledge, regarding the services provided in the research borough by voluntary sector organisations, *The Collaborative* was the first organisation service users had ever contacted for low-level listening, emotional support, and to obtain guidance and information.

The acute hospital in-reach project was part of the discussion for Focus Groups 2, 3 and 4. As part of the project, the voluntary sector staff would go into a hospital with the focus on helping people stay well. This project supports the client in the ward and, when discharged from the hospital, they have a relationship that they can build on:

> *"So, if something starts to happen, they can talk to somebody that they already know, not a clinician or not with clinical eyes, but more than with an equal. We can signpost and allow people to achieve their goals and keep them out of hospital." (FG2, p7)*
>
> *"It is really when an individual goes for an assessment, either to A and E or following a call with someone on the crisis line, and it is deemed, because they are presenting with quite complex or difficult needs, what would best suit them is three weeks of support, provided once a week. You can scope out exactly what has gone on in recent history, exactly what they think is the cause of their crisis and mental health needs and help to build confidence and signposting to appropriate services again." (FG3, p10)*

The participants identified the risks managed by the voluntary sector staff due to the pressures on the service and the funding cuts. They were eager to see more in-house support, which they believed would bring positive outcomes for the service users.

> "*People would respond really well to having in-house groups - for example an English language group, meditation group and a men's group. These are ideas, but it hasn't been feasible so* far." (FG4, p15)

Feedback from service users and carers can inform critical reflection, individual oversight, assessment and ongoing employee development. Some of the front-line employees themselves are service users.

Therefore, *The Collaborative* highlights the significance of knowing about the experiences of individuals with disorders of mental health to encourage empowerment and the 'voice' and choice of service users.

> *"We get qualitative feedback from people because what we don't want to do is give a service where we don't know if we are actually over-performing or underperforming. So, we do ask for qualitative feedback. Sometime last year, with the consent of the people, a video recording of feedback of service users was taken on how the services have been impacting them and how it has worked."* (FG2, p6)

The participants acknowledged that sometimes the patient just wanted to have an ordinary dialogue without being blinded by medical science. One of the benefits discussed in the focus groups was that the voluntary sector staff can work with the service users for up to two years, maybe even more, rather than 12 weeks.

> *"It is about how we communicate with a client to offer unified mental health treatment for people in need, with cooperation and compassion."* (FG1, p4)
>
> *"Having the two years to work with the client gave me the time to understand their real issues and work with them on their recovery journey."* (FG2, p8)

7.2.2 Theme 2: Successes and Achievements

Similar to the semi-structured interview findings, this was the second theme derived from the five focus groups discussions. The participants were enthusiastic and motivated about identifying and sharing *The Collaborative*'s successes and achievements as they experienced the improvements in the mental health of the service users every day. The achievements were:

- Person-centred care
- Outcome-based care
- Housing
- Education, training, volunteering or employment

The achievements that were identified by the front-line staff enabled the providers, including the statutory sector and the voluntary sector, to be explicit as to what personalisation and person-centred work each service represented, as well as the willingness of suppliers to explore beyond-service delivery models. The participants found that service users had assets, such as expertise and skill, that could be put to good use to enhance services through multidisciplinary teams and peer support.

7.2.2.1 Person-Centred Care

The participants confirmed that they always looked at the whole person, considering each person's needs and their goals, focusing mainly on people's employment, housing, health status, medication, education, involvement in the community or anything else that could impede them in reaching their goals. For all the psychiatric nurses in the focus groups, Carl Rogers' concept of person-centred therapy as an intervention that allowed the patient (rather than the doctor) to be the ‘expert’ in the recovery phase from illnesses, had impacted their primary approach to mental health.

The participants confirmed that *The Collaborative* emphasised co-design and co-production and that this involved as many stakeholders as possible, including the clients themselves, into shaping the service.

The focus of person-centred care was on short term support, with people expected to be seen for up to 12 weeks. Even though some participants mentioned that the short time to make a difference to an individual was not enough, some confirmed that the short-term support service did work because it gave the power back to the client to make some informed choices.

> “*Once you are given a client, you are focused and you try your best to make sure they have got what they need. And that is where my role is. I am there to support the support workers and I follow up on the clients and try to make sure they get to that place where they are strong enough to work to be independent.*” (FG3, p11)

According to a mental health nurse, this was reported to lead to feelings of satisfaction for the service user even though the staff were constantly being given targets that they had to fulfil, including closing the case after six weeks:

> *“In my opinion, the Collaborative Centre was the purpose of The Collaborative, providing a more flexible service to meet people’s needs in a manner that is best for them. I feel like the whole reason it is there is everyone has access to every service i.e. every other service. We make sure that everyone, who come through the revolving door has access to all the community resources and we are there to work with the clients who need that extra support for their mental health, clinically.”* (FG5, p18)

There are different pathways that the client could go through. For example, the mental health pathway is different to the homeless in that there is more choice given to the client on the demographics, type of accommodation and type of support available. The participants’ comments are summarised below:

> *“In terms of the things that would actually benefit our clients on improving them is making sure that they are not being stuck in places where they may be getting more institutionalised. They know that we are professionals and they can trust us.”* (FG1, p3)

7.2.2.2 Outcomes-Based Care

Most of the themes arising from the focus groups findings are similar to those of the semi-structured interviews. However, outcome-based care is one of the new themes for the front-line staff. Even though the collaborative outcomes are widely known, for the participants, they do not look at these outcomes on a day-to-day basis. For the different services offered by *The Collaborative*, outcomes and service user satisfaction are measured to check whether collaborative outcomes are achieved. What is important is their contribution to social inclusion and helping clients around more practical tasks, as well as linking them with different agencies. The participants shared that achieving the collaborative outcomes was part of their role.

On the discussion of achieving the outcomes:

> *"I have a bit of difficulty with this idea of the outcomes because they seem very much ideal world kind of outcomes, while we are trying to encourage people to have more of a sense of agency around their choices. It is not like it is a definite goal, which is necessarily reached or completely reached in the options and forms of support we offer to clients or we will try to help them to engage with."* (FG2, p5)

For three-quarters of the participants, when evaluating each of the collaborative outcomes, for example, in terms of participating on an equal footing in daily life, such an evaluation was about the inequality and the social inequalities in the research borough that were experienced by the client group. There are multiple levels of social exclusion which are challenging to resolve or begin to tackle.

For some services of *The Collaborative*, the main objective was achieving the collaborative outcomes, but there were financial constraints.

> *"I think it would do a disservice if we didn't talk about it."* (FG3, p10)

On the 'recover and stay well' aspect of the collaborative outcomes, the ART of Integration Alliance was a good example of this operating in practice. The voluntary sector staff were involved in the rehabilitation team and working with people often still in the hospital. They supported them in their recovery through to leaving the hospital and going into supported, or any other, accommodation. The support was focused on social inclusion and the prevention of isolation.

> *"We are keeping in touch with people by visiting them on a regular basis, building a rapport with them, getting to know them in a sense that we would be able to support them and recognise the signs of what is going on for them."* (FG2, p8)

From the feedback from the clients via the front line staff, feeling supported was valued and the personal qualities of the relationship with a support worker helped to meet the collaborative outcomes or different goals. The focus group discussions with the front line staff revealed the impact of *The Collaborative* on the culture and ways of working of staff, as was presented by a psychiatric nurse and lead peer support worker:

> *"There is a very strong emphasis now within the NHS on gathering a lot of quantitative data, key performance indicators and really producing quite a lot of data. From the feedback I have had recently from clients, there is so much more onus on the importance of the patient feeling supported and the personal qualities of that relationship with a support worker than meeting X or Y goal."* (FG5, p18)
>
> *"For support workers, sometimes we carry that tension between trying to quantify stuff which isn't easy to quantify for the sake of the system but also meeting clients in a perhaps less formal way than a traditional psychiatrist or nurse might meet, in that space. There is a certain tension there."* (FG4, p15)

For most participants, outcomes were measured by:

- admissions to hospital,
- fewer admissions to sectioning,
- less self-harming,
- how the clients were generally adapting, their appearance, how they were growing, fewer incidences of overdosing,
- fewer admissions by ambulance,
- the police had not been involved, and,
- ultimately, improving the quality of people's lives.

During the discussion of evaluation of services, a lead peer support worker confirmed:

> *"Fewer people being admitted in hospital for less time and engaging more in the community once they have been discharged. The Electronic Patient Journey System (ePJS) is another way we measure the frequency of how often they are contacting us."* (FG4, p15)

For some services, outcomes were measured from the service user feedback. Mostly, quantitative data is captured from the IAPT (Improving Access to Psychological Therapies) perspective, following the crisis line contact log or community service intervention. The participants also measured success by looking at savings, move-ons and cost-effectiveness. If the person is moved on and if they are happy for six months, that is how success is measured in a straightforward way.

> *"We have people coming to the Collaborative House for 10 years. If they are contributing to the mental health system for 10 years and no one is listening to them, no one has believed that these service users could have achieved anything. But once you put them in the centre, there are impacts. We have one person who wants to be cleaner and we managed to get him a day cleaning job. So those are really good outcomes that we use to measure."* (FG3, p10)

Giving more roles and responsibilities to individuals who have been out of the mental health system has resulted in them thriving in their positions. User involvement within *The Collaborative* has also been linked to beneficial clinical outcomes, such as greater self-esteem and confidence, as well as the therapeutic advantages from increased social engagement.

7.2.2.3 Housing

The participants shared that addressing the wider determinants and mental health risk factors, including housing, employment and destitution, e.g. via strengthening collaboration among local authorities in assistance of persons with housing, financial or legal difficulties, was one of the priorities. The local authority had signed a Section 75 partnership agreement with the NHS and CCG for the establishment of commissioning funds for mental health rehabilitation services, as revised by the National Health Service Act 2006 (Health and Social Care Act, 2012b). The Council had established an Alliance Agreement with providers to promote the reform of health and social care provisions using this pooled funding. The discussion with the front-line staff had progressed with the Alliance Agreement, including the establishment of a multi-agency community recovery provision to enable personalised assistance for recovery. The individuals, who were using the service were, therefore, allowed to move from institutional care to social housing. Focus group questions regarding steps taken to achieve the collaborative outcomes, the front-line staff shared:

> *"Key service developments included reducing hospital rehabilitation requirements and the establishment of a community-based, intense community recovery centre. This means restructuring the existing seven-beds scheme and supplying 20 self-contained dwellings via voluntary sector organisations and the provision of social housing units by the social care quota of the local authority."* (FG1, p2)

A critical part of the service offered was the provision of housing and improved joint working between housing providers and mental health services.

The participants also shared the new roles being created to support housing and reduce financial pressures.

> *"The housing specialist role was created to identify people, who are stuck in either a bed somewhere or project where they no longer meet the needs and are ready to move on."* (FG3, p11)
>
> *"Helping and unblocking those top echelons mean that they came a step down in the service and when we looked at the evaluation after less than nine months, two voluntary sector staff had saved £288,000."* (FG1, p3)

The participants also revealed how they measured outcomes in housing.

> *"In the housing role, our main measure of success is to understand whether a client is able to remain there after three months."* (FG1, p3)

The supported housing service provided assisted housing to enable individuals with mental health issues to live as independently as possible by strengthening their talents, confidence and self-esteem. According to participants:

> *"This supported housing contract offers accommodation and support to people who require them; some of whom have complex needs, homelessness and substance misuse issues. Many people would otherwise have been placed in higher support placements, such as residential care."* (FG1, p4)

The Collaborative's work with the voluntary sector organisations addressed significant budget overspends in inpatient beds, community support and supported living.

> *"So, with voluntary sector organisation, we did something futuristic. How do we use our voluntary sector colleagues to think more innovatively about the housing that they could create, rather than coming to the council? The Collaborative had enabled us to do just that."* (FG2, p6)

7.2.2.4 Education, Training, Volunteering or Employment

The participants shared that as part of the collaborative outcomes, one of the aims was to increase the numbers of people in education, training, volunteering or employment. A sense of purpose is central to good mental health, and many get theirs from studying, work or volunteering. *The Collaborative* works with partners to employ, support and develop people. On the discussion of measuring to see if integrated working supports a better quality of life for people, a participant from Focus Group 4 shared:

> *"We have developed an employment strategy to support people with mental illness into meaningful employment. However, there is much to do."* (FG4, p14)

Collaborative Recovery College offers a learning approach with co-production at the heart, giving the resources to assist people with mental health difficulties to become leaders in their own rehabilitation.

> *"The seminars and courses we provide are designed to give skills that assist people to develop expertise in their own recovery. Each programme and workshop is co-conceived and co-managed by professional mental health instructors and those trainers with lived experiences. Our webinars are free and accessible to everyone, anywhere."* (FG2, p5)

The Employment Academy was another option shared by the participants to provide the support to employment, voluntary work, training or educational provisions:

> *"It is run by one of the partners of The Collaborative. I have referred a number of clients there. So, ordinarily, pre-lockdown, they would get a peer mentor that would sit with them for about an hour and really explore all of their past work history or past training to understand training gaps. If they are not ready for work, they can find voluntary options for them. And at the centre itself, they even have a painting and decorating course for people that are interested. So, they have got lots of contacts with different industries. They are able to really connect with those, whether its accountancy, whether it is admin, whatever it is, they can help them with."* (FG1, p2)

The participants also shared the partnership working carried out by *The Collaborative* in increasing employment opportunities for people, such as setting up a local garage with mental health support needs.

> *"There are working garage, where people bring their car to repair and for MOT. You can choose which area in the life of that garage they can work in. You can work in the back office to do all the ordering of the parts. You can either do the spreadsheets, the accounts, or you can work on the shop floor where you repair."* (FG4, p14)

7.2.3 Theme 3: Challenges

All the focus groups with the front-line staff of *The Collaborative* discussed the challenges experienced and how *The Collaborative* had influenced positively the residents' mental health. 'Challenges' comprises the third theme under the focus groups findings. The themes derived from barriers by the focus groups were financial constraints, differences in staff culture, COVID-19 and stigma, which are explored in detail below. Although some of these themes are similar to the semi-structured interviews, there are some variations. For example, under the theme of Challenges, the semi-structured interview data revealed sub-theme such as ethnic disparity.

7.2.3.1 Financial Constraints

Some of the participants shared one concern when measuring the success as they believed only financial success was measured. One lead support worker illustrated:

> *"My role is to look up people stuck on the wards, like complicated discharges, people who are stranded, and they are often the ones who need a lot of professional input. It is expensive to get them off the wards. The health service has a false economy. For instance, if a client in the ward wants to come out and the placement may cost you £2000 a week, it is a lot of money, but they are stuck on the wards because no one is agreeing to that placement. If they are in the wards, it costs them £500 a day. £500 a day in the wards, but if they get the discharge and they come out, its cost is £2,000 a week. The Collaborative opts for the placement because it is cheaper."* (FG1, p1)

The discussion continued in the same focus group on the impact of financial pressures on the service users' mental health and a voluntary sector support worker stated:

> *"But sometimes, short-term loss is long-term gain. People don't often see it. It is immediate pressure financially, but sometimes, if you use money the right way, spend the money where it should be spent, then the longer the term is, it is better for everybody. The client gets what they need, for example, more choice and control, and they can recover and stay well."* (FG1, p3)

The participants shared that the target saving was in the range of 20-25 percent when the Integration Alliance was set up, which meant that they attempted to change how care was provided and how it could lead to better outcomes for the service users, with considerable savings at the same time. For one of the voluntary sector staff,

> "*The Integration Alliance concentrates heavily on the transition of systems. It focuses on how secondary care, VCS services and social care may be better integrated to provide the positive outcomes and achieve circa 20 percent savings by year 2.*" (FG2, p6)

The NHS staff, such as the mental health nurses, care co-coordinators and the psychiatric nurses, emphasised how grateful they were to the voluntary sector staff in supporting people with mental health problems, a consequence mainly of the financial constraints.

> *"The third sector can play a significant role in bridging the gap between commissioners and local communities when it comes to assisting people with mental health concerns. That is because of the cut to services that were provided by the NHS previously that no longer exist for specialist groups of people."* (FG5, p18)

They affirmed that statutory services were a significant component of the response to mental health and that the voluntary sector had an essential role to play in reacting to cost reductions of statutory services, closing shortfalls in provision and reacting to policy initiatives.

> *"Lack of resources, especially financial resources, is a huge factor. If we don't have access to those resources or that service is not there, then we can't provide it. I know my voluntary sector staff are having increasing demands placed on them to hold caseloads of clinical clients that they normally wouldn't hold because we have a shortage of clinicians and can't afford to employ more. The demands of voluntary sector staff have increased substantially, and the expectations in terms of what they are required to hold."* (FG5, p19)

The lack of training in the new system, which was described as counterproductive, was highlighted by eight participants, and they believe this was due to financial pressures.

> *"A database called Inform is used when we are doing assessments with our clients to record or capture information. I found just getting to learn the ePJS (Electronic Patient Journey System) and the new system were a mammoth task without any training. So, that was a big barrier affecting our productivity."* (FG3, p10)

Five participants talked about the transition from CH, which had more voluntary sector staff, to the Collaborative Centres.

> *"As voluntary sector staff, when I went over from the Collaborative Hub to Collaborative Centres, I was expecting that certain things were put in place, e.g., software, having somewhere to sit and chairs. The clinical staff also didn't know what we were doing and for some time, some of us were just sitting around doing nothing. These decisions were made in order to avoid loss of funding and to meet the strict deadlines."* (FG1, p2)

Half (N = 10) of the support workers believed that one of the biggest struggles for service users was the lack of continuity of care as the care coordinators left soon after the service users became comfortable with a care coordinator.

7.2.3.2 Differences in Staff Culture

Differences in staff culture was a new barrier that the focus group participants emphasised. This did not figure in the semi-structured interviews findings. The participants shared how the tension between the voluntary and statutory sector staff was due to the lack of understanding of the staff structures in the two systems, issues with data sharing and the perception of voluntary sector staff being not as 'professional' as those in the statutory services.

One participant shared about the frustration of the transition from the voluntary sector to the integrated system:

> *"I wasn't working in community or in the crisis team. And it was a huge difference for me to come all the way from supported accommodation to community services. In supported accommodation, we have to do support plans and do one to one sessions. In the community crisis service, we have to attend multidisciplinary team meetings and work directly with care coordinators, doctors and consultants. It was difficult to understand the structure of the teams and the roles and responsibilities of the team members. The first thing I had to change was my sense of way of working."* (FG3, p10)

During the discussion, one voluntary sector participant shared how colleagues had provided the support to address the barrier:

> *"With the difference in work culture, my manager really pushed me to do better. So, integrating into the culture was really hard in the beginning, but it ended up working in the end because I ended up learning more."* (FG1, p2)

The statutory sector staff also experienced the challenges of the transition to integrated care. One of the mental health nurses stated:

> *"It was really difficult for me to understand how other structures worked and how the team would work basically with the voluntary sector. Strange for me, and I guess it is because I have not used to working in that way before, and the structures are not really clear."* (FG5, p17)

According to the participants, due to the shortage of clinicians, having more volunteers to support the clinical and the non-clinical staff made a huge difference. *The Collaborative* offered third-year pharmacy students and some doctors, who had volunteered.

> *"Often, you can see a big difference in the attitude and, in my heart, I am thinking, 'When you are not qualified and dispensing medicine or surgery, you can look at John (name is changed for ethical reasons), one of our members, and you got to see him as a person as opposed to a system or a system that has got to be fixed'."* (FG3, p10)

The expertise required to provide integrated care is often currently prevalent in the workforce and the participants confirmed that the challenge was how these skills could, as part of an integrated system of care above and beyond organisational borders, be shared and disseminated. Compulsory training for the front-line staff was highlighted as helping them to support people with mental health problems. One of the care co-coordinators, who worked both in a hospital and in the community, shared:

> *"Sometimes the hospitals bring agency staff in for one day and they get ignored by the statutory sector staff due to the lack of training. Communication, management and relationship-building skills are essential and may be more widely needed by professionals and non-professionals. Interdisciplinary development, management training, practitioner skills development and corporate training programmes can contribute to the growth and distribution of the required talents and capabilities."* (FG5, p20)

The voluntary sector staff confirmed that they believed they were the closest person to the client, professionally, apart from the family. They felt they should be considered the same as nurses, police or even paramedics. One of the voluntary sector participants confirmed the cost-effectiveness of *The Collaborative* staff, having saved £300,000 through early hospital discharge, participation in society and reduced carer burden. However, it was suggested that if this had been in the footprint of clinically trained staff, the publicity and recognition would have been much better.

For voluntary sector participants, operationally, their sector was more flexible than the statutory sector services and was consistently learning and evolving so that they could develop operational policy and procedures.

> *"For a statutory service, that is quite unusual to constantly evolve as there are a set of parameters and they are scared about evolving. We try not to do it that way because it is hard to have something that is set in stone and not knowing what the outcomes are going to be."* (FG3, p11)

The participants spoke about systems leadership, factors of credibility and asymmetry which impair the spirit of collaboration needed for the effective integration of health and care services. They acknowledged the importance of being credible and a need for mutual respect to overcome divides and facilitate cooperative services across health and healthcare organisations. Trust between individuals and/or institutions depends on one party's judgement to rely on another party in terms of risk. The regular meetings, integrated working and being in communication has enabled them to minimise tension between the voluntary and statutory sectors, where possible. Some participants raised the issue of institutionalism, where the voluntary sector staff were getting talked to in a certain way by a psychiatrist or a GP, even though they were filling gaps in service provision or had established innovative care models, including accessible valuation, self-organisation, crises user-defined notions, informality and relational methods. The hidden aspects of the voluntary sector staff role were explained as:

> "*There is a lot of service that the voluntary sector staff like us do that the clinical staff were unaware of. Integration has made their job a lot easier as well. In practical terms, the clinical staff have done all the medication for the client with you, and they have also done the mental health assessment. Now they are able to hand over that patient to the voluntary sector staff, then we can work on with practical elements and solutions with the clients to carry on with their lives and make them independent."* (FG4, p15)

Both sectors agreed that they have their part to play if they are to transform people's mental health and wellbeing. According to one peer support worker, who is a voluntary sector staff member:

> "*I do feel like my knowledge of other services and the social care team and different agencies who we work with closely has improved as a result of knowing more people from these teams and having more connection to them."* (FG2, p6)

'Address the cultural difference' and 'strengthen the communication' are understood to be a priority for *The Collaborative* when re-sharing the services.

> *"Moving forward, there is a plan around building better communication anyway with the services in Collaborative Centres."* (FG4, p15)

> *"In the Collaborative Centres, with partnership working, we are sending the messages out, making sure that it is consistent across all the organisations. We have leaders from different organisations, talking between them, rather than to themselves."* (FG2, p8)

One participant summarised the importance of communication as:

> *"The collective priority is on people's outcomes in accessibility, quality of treatment, and experience, and providers are encouraged to improve communication, be more productive, and avoid repetition."* (FG2, p5)

One psychiatric nurse concluded the discussion on the differences in staff culture with a positive contribution:

> *"I do think we work well as a team and it is actually great to have the support workers on board in our team and, they bring a different sort of perspective to mental health support."* (FG5, p19)

7.2.3.3 COVID-19

As four out of five focus groups were conducted during the COVID-19 pandemic, the front-line staff shared what impact it had on the mental health of the residents. During COVID-19, they experienced the busiest months on record for a mental health crisis line. They experienced an increase of 800 percent in the calls compared to the previous year, and many individuals contacted the mental health services for the first time in their life as they experienced difficulties.

The COVID-19 situation forced services to redeploy staff from one service to another due to the increase in demand for the services and to support areas where staff were off sick or self-isolating. As many as 14 out of the 16 participants highlighted how they had been exposed to numerous stressors, including unexpected roles and responsibility shifts, including crucial decision-making, rapid escalations in workload and coping with the culture difference in the new setting due to redeployment. The COVID-19 had created changes in staff redeployed from the community service to A and E. This is how one participant experienced the transformation.

> *"It was a huge culture change because you are working with a different department's cycles, but it wasn't quite working for some staff because it was not easy to adapt to change, especially so quickly. And there was no warning and no previous training given. When patients are quite psychotic, the voluntary sector staff are not trained to deal with high-risk patients. As securities are available at the hospital and the staff are never alone, therefore we felt protected to a level."* (FG4, p15)

The interview data revealed examples of how the participants have adapted to COVID-19.

> *"So, it is a huge difference that you definitely have to adopt. But it is working for me, though, and I am enjoying it."* (FG3, p11)

> "*In the Crisis Café, the staff are in the community where they can actually see people. With the COVID-19, it has to be virtual. Only so much we can do due to all the services are closed or restricted.*" (FG3, p10)

Due to government guidance during COVID-19, the staff had not been able to see the clients, but they were being supported via telephone and accepting new referrals via email.

> "*We have all got to get used to a new way of working with the current situation, which is difficult for us. It must be ten times more difficult for them. Apart from the more practical support we offer, I have also spoken to a couple of clients recently who I hadn't met before in person due to lockdown. I found being supported over the phone during lockdown really beneficial.*" (FG4, p16)

COVID-19 presented far-reaching challenges, including highlighting inequalities in health outcomes. Similarly, one care coordinator highlighted the digital inequality due to COVID-19.

> *"One of the things during the lockdown, and is noticeable, is that some people don't have access to computing or digital skills. Moving forward, it is important to address basic computer training within the community, especially for people with mental health issues."* (FG5, p19)

COVID-19 also had an impact on communications.

> *"Because of lockdown, the teams have become quite fragmented. We split up into different teams to avoid cross-contamination. So, it hasn't felt integrated and it feels like a lot of teams within teams, not in a bad sense, not as a critique of anyone or anything, but just as a kind of inevitable process, with the lockdown." (FG5, p18)*

It has had its advantages, and according to Participant 7:

> *"We are definitely seeing a growth in terms of productivity in achieving the service user goals."* (FG4, p16)

7.2.3.4 Stigma

The focus group discussion included participants' accounts on how the collaborative outcomes were aiming to encourage service users to participate in daily life on an equal footing with others and, specifically, to be included in society with reduced stigma and discrimination.

One participant said *The Collaborative* had received recognition nationally as a service user had published a book.

> *"Inspired by the work of one of the services of The Collaborative, Collaborative House, a service user has published a book on – reducing mental health stigma in the workplace. Collaborative House's Transitional Employment Programme model enabled members to develop various expertise and shift to jobs that have a beneficial effect on their life. The awareness of the programme needs to be improved among more employers."* (FG2, p6)

The participants reflected that good mental health can never be achieved because issues such as access to housing, supporting people on the pathway to work, maximising people's income, relationships and stigma make some communities reluctant to access mental health services.

> *"The Collaborative Alliance has always been working to reduce mental health stigma and prejudice, to increase the knowledge of mental wellbeing and how to stay well and to raise knowledge of how individuals may receive care in the borough."* (FG1, p1)

With the demographics of the London borough, it was recognised there was a need to improve resilience, wellbeing and to reduce mental ill-health and stigma in Black communities.

> *"Through Collaborative Thrive, members of the local African and Black Caribbean community have greater accessibility on local and national matters in order to improve understanding and reduce stigma."* (FG4, p13)

Focus group data indicated how the Collaborative Alliance was trying to adopt mental health stability in the borough in cooperation with other health institutions and the local community. Developing an asset-based support paradigm offers a substantial opportunity to address the mental health stigma. To achieve this, it will be crucial to develop strong interactions with local populations.

7.3 Chapter Summary

The Collaborative's front-line staff, including the support workers, support work managers, care coordinators, mental health nurses and psychiatric nurse, discussed partnership in the working of health and care organisations in a logical and reasonable manner, addressing complex factors such as staff culture, communication and working practices. This chapter has highlighted how the priority is to provide improved and more holistic treatment that might assist most individuals with mental illness. As all the participants in the focus groups were front line staff, they emphasised the importance them being involved in the collaboration for decision-making. In addition, the successes and achievements and challenges identified in the discussion with the front-line staff concerning *The Collaborative* could be seen to enable caregivers, volunteers, primary, secondary and social care providers, and commissioners to work with patients in an integrated way, and to establish and evolve similar provisions in other areas.

Even with the challenges, it is important to remember how far *The Collaborative* has come resulting in the borough being recognised as one of the best for providing mental health services, according to the participants. It is exciting for some participants as some of the services that have been static for more than 20 years have restarted and been absorbed into the Collaborative Centre. The support workers repeatedly emphasised their commitment. There was a real feeling that they believed they were making a positive difference to extremely vulnerable people in their community. Cross-sector health and care services collaborations are neither straightforward nor novel, and these endeavours are largely top-down and statutory services-led. The functioning of *The Collaborative* offers a vital platform to learn from real-world experience and what contribution the mostly unexplored VCS can and should make in developing partnership.

CHAPTER 8: DISCUSSION

8.1 Overview

This chapter will discuss the findings from this research and present them in the broader perspective of other literature and studies. This study aimed to explore and examine integrated working within *The Collaborative*, first established in 2010, where local stakeholder groups such as service users, caregivers, voluntary sector providers, primary care, social care, commissioners and secondary care, have worked to bring changes in the mental health system in a local authority.

The literature review presented the studies and publications of service user accounts of mental health provisions, the lack of leadership, and the front line staff's views of mental health care in different parts of the world. Having conducted the case study, a further review of the literature during the discussion stage identified more recent studies, which confirmed similar gaps in knowledge. It was decided that documenting the experiences and accounts of the leadership team and the front line staff (Wynaden et al., 2005; Mayblin and James, 2019) who make policy decisions and provide daily support to the population in one London borough (Abbara et al., 2016; Almoshmosh, Mobayed and Aljendi, 2016) would help to establish a comprehensive framework for exploring and understanding of the needs of people with mental health issues in the UK and, potentially, in other parts of the world.

In England, developing integrated mental health strategies has been a significant development. In many cases, mental health is isolated from the general health and care system, resulting in difficulties in administering synchronised assistance for physical, mental and wider social needs. A closer look at the literature on integrated mental health care, however, reveals several gaps and shortcomings in service provisions for adults.

In the context of these gaps, initially, this chapter discusses and places the significant outcomes of this study in the broader perspective of other publications and research. This study has identified several findings from the three phases: phase one of documentary analysis; phase two of qualitative discussions with leadership teams, and phase three of qualitative discussions with front-line staff, and these are detailed below. In addition, the findings from the independent evaluation of the Collaborative Hub conducted by the charity on the service users and carers perspectives is incorporated in the discussion. The evaluation included 8 service user interviews, 84 client satisfaction questionnaire and 69 responses on the telephone survey. Next, the main findings of three phases and the independent evaluation of this research study are considered in the context of the existing literature. In line with a triangulation approach, following individual analysis of the documents, semi structured interviews and focus group data and the independent evaluation, the data sets were compared and contrasted (Creswell and Clark, 2017). In the following paragraphs, the findings concerning the main research questions will be discussed.

8.2 Aims and Research Questions Revisited

The research was aimed at learning from the documentary analysis, the views and experiences of the leadership, professionals and front-line staff on how *The Collaborative*'s processes were implemented, impacting the mental health of the population. The focus of this study has been on the function of the policies which have played a role in implementing and supporting the mental health provision by introducing integrated care. It also looked into the degree to which community mental health service providers and the voluntary sector have collaborated with the NHS, the local authorities, and commissioners, as well as the extent to which these community programmes have corresponded to service users' mental health difficulties. I was also interested in learning more about what might be done to improve policy and practice recommendations for integrated mental health services to improve the mental health of the local population. Developing a thorough understanding of *The Collaborative* may have aided in improving care and facilitated future considerations, such as the removal of potential barriers to accessing mental health services and finding solutions to implement similar provisions in other parts of the UK and the world, depending on demographics.

The research objectives, questions and sub-questions were as follows:

8.2.1 Objectives

1. To analyse relevant policy documents to identify the priorities that have played a role in implementing and supporting *The Collaborative*.

2. To critically consider the impact and implications of policy development (2010 – 2018) leading to the establishment of *The Collaborative*.

3. To explore the views and experiences of the leadership team and professionals working within *The Collaborative* on the process of implementing the initiative and its impact on the mental health of the population.

4. To explore the views and experiences of the staff working within *The Collaborative* on the process of implementing the initiative and its impact on the mental health of the population.

5. To identify the possible effects of *The Collaborative* on the service users on their mental health condition, based on the views of the leadership team, professionals and staff.

6. To provide policy and practice improvement recommendations for integrated mental health provisions based on the application of findings from the study.

For the purpose of this chapter, the main research question, *How has The Collaborative facilitated the integrated care process for mental health outcomes in one London Borough* provide the structure and the focus of this discussion along with the sub questions

- How has the policy development (2010 – 2018) impacted *The Collaborative*?
- How do *The Collaborative's* leadership team and professional teams influence service user outcomes in mental health services?
- How do *The Collaborative* staff teams influence service user outcomes in mental health services?

8.3 The role of *The Collaborative* in facilitating the integrated care approach for mental health outcomes

To direct policymakers towards how best to implement integrated mental health services, it is necessary to know the policies which were used to establish *The Collaborative* and how *The Collaborative* facilitated the integrated care process for mental health outcomes. This thesis has shown that the five partner organisations felt that they were offering support to the people with mental health conditions, even though there were barriers. In particular, the leadership team and the front-line staff shared their views of the role of voluntary sector organisations to help address the inequalities and provide person-centred and outcome-based care for people with mental health conditions as they were closest to people who used the services. Similarly, policy documents in integrated care have enabled organisations to work together and the voluntary sector to be more involved. The findings of this study highlight how the underpinning principles of collaboration, peer support and empowerment have brought the five organisations together; allowed the multidisciplinary team to achieve better access to housing for the service users, and emphasised the role of peer support and digital peer support during COVID-19. They have exposed the inequalities in the system in terms of parity of esteem, socio-economic factors, culturally sensitive mental health care and stigma, and have noted how these continue to be important impediments to obtaining mental health treatment and accessing psychological assistance. The stakeholders acknowledge that the service is constantly evolving, responding to feedback, and explain the help they require to sustain high levels of support. This research will contribute to the increasing literature related to policy development in integrated care and mental health to ultimately inform other local authorities when implementing changes to improve the mental health support they provide. The main findings of this research will be explained in detail in the subsequent sections.

8.3.1 Implications of policy development during 2010 – 2018 on *The Collaborative*?

According to the local documents, starting from 2010 to 2018, the drivers, that have encouraged the research borough to introduce *The Collaborative* included financial pressures, communication and information-sharing across agencies, shared vision and leadership, organisational culture and professional boundaries, the workforce, and a place-based approach. These data are similar to those reported in Leijten et al.'s (2018) study to develop a conceptual framework that can aid the development, implementation, description, and evaluation of integrated care programmes for multi-morbidity. It highlighted the core of the framework in the holistic understanding of the person's environment and the components of health systems such as service delivery, leadership and governance, workforce, financing, technologies and medical products, and information and research. All the seven collaborative-related policies were intended to improve the health of and reduce health inequalities for people in the local authority, which is one of the social issues these policies intend to tackle. The documents explored the way of working, how *The Collaborative* organised services around people and places and how the services were brought together as a whole system. All documents emphasised the importance of national and local policy in driving change throughout mental health services in the research borough. In particular, 'Confederation Proposal' stated the influence of the national policies such as 'No Health without Mental Health', 'Five Year Forward View for Mental Health' and 'Sustainability and Transformation Plans' in developing *The Collaborative*'s processes.

The main actions from policy intentions of *The Collaborative* documents were to create new governance focused on 'best for local people', develop integrated management and coordination for the local authority, create a single set of outcomes that show a whole system approach and develop new financial arrangements that move away from organisational silos to support services around people. This contradicts Goodwin's (2019) description of little evidence available on how to implement integrated care and relatively few integrated care programmes have expanded beyond the initial pilot phase and become mainstream. Hence, it remains largely unclear which implementation strategies contribute to successful upscaling and sustainable integrated care programmes that are structurally embedded in the health and social care system.

A number of policy documents have addressed the issue of enhancing integration by focusing on the significance of both mental and physical health and highlighting the disparities in health care that can arise when social and economic factors interact. Job security, a safe place to live, and the absence of prejudice or bias are some of the socioeconomic elements highlighted in the policy documents. It is clear from reading the policies that disparities in mental health care are prevalent, especially deprived communities, such as BAME, and the people with disabilities.

Reflecting on the outcomes of the documentary analysis, the discussion will now include the findings from the semi structured interviews with *The Collaborative*'s leadership team, focus groups with the front line staff and independent evaluation and whether these findings support the documentary analysis outcomes, influencing service user outcomes in mental health services.

8.3.2 Compare and contrast the documentary analysis findings with the impressions of leadership team, front line staff and data from independent evaluation

In the research borough, mental health was moving up the policy agenda and was influenced by the national policies. Even though there were barriers in implementing the policies, the qualitive data confirmed the vision of the research borough in moving the system from being crisis-dominated to one focused on prevention, early intervention and enablement. This contradicts the research findings of the qualitative study on general practitioners' perceptions on their role in light of the NHS five year forward view (Humphrey and Cleaver, 2018), where the GPs embraced the principles underpinning the new care models, however they were reluctant to adopt their new roles, struggled with inter-organisational and cultural barriers and changing professional identity. The qualitative data in the current study identified many factors that influenced service user outcomes in mental health services.

8.3.2.1 Contribution of Voluntary Sector

In the research borough, connections between various professionals and diverse health and social care organisations are being established and relations strengthened. The documentary analysis findings under 5.2.1.1 emphasised the importance of Alliance Rehabilitation Team (ART), a multidisciplinary team under *The Collaborative* which co-ordinates volunteer and statutory institutions to better help persons in need. The team members are supporting those who would have previously been admitted to the hospital by providing them with extra home-based care. The 'contract culture' that started to emerge in the 1980s enabled the third sector organisations to be involved in the delivery of social care (Dickinson et al., 2012). In the current study, data from the semi structured interviews, focus groups and the independent evaluation acknowledge that the VCS organisations and staff have provided guiding leadership in developing recovery-orientated and peer support approaches. In addition, care models were established and through a non-medical response, focused on the care users' situation, aiming to empower them to deal with their crises, and offer alternative or supplementary provisions to statutory crisis measures. To my knowledge, this has been a distinctive addition to the current literature on the contribution of voluntary sector organsiations to integrated mental health systems. According to (The King's Fund and NHS Improvement, 2016), the characteristics that are fundamental to a healthy culture include inspiring vision and values; support and compassion; learning and innovation and effective teamwork and collective leadership. These are offered by the VCS organisations and staff in the research borough. Based on information gathered through semi-structured interviews and focus groups, it is evident that some of the service users and carers of *The Collaborative* are actively involved in the VCS organisations as volunteers in roles such as peer supporters, providing training, support skills development, co-designing the service specifications, commissioning and procurement process for funding and becoming trustees. The variety of offerings in the VCS is not fully known, nor can it be properly aligned to that offered by statutory services, even though the current policy promotes this (2010 to 2015 Government Policy: Social Enterprise, 2015). This finding corroborates the results of the multimethod study of the voluntary sectors' contribution to England's mental health crises which examined the knowledge gap in mental health crisis treatment regarding its contribution and engagement with public services (Newbigging et al., 2017).

Data from the documentary analysis, in particular the document called 'Integrated Alliance – Adult Mental Health' suggested the creation of a multi-agency community rehabilitation service to provide personalised recovery packages of support. Some members of the leadership team have highlighted the implementation of the talking shop, the peer support hub and 'collaborative in crisis'. Another example illustrated by the participants in the semi-structured interviews is the successes and achievements in the housing provision within *The Collaborative*, where community services and the accommodation-based services were developed to support moving service users from restrictive settings into community settings. This has resonance with the accounts of service users in Trevillion et al. 's (2022) study as they highlighted that community services can best support people with complex emotional needs. Drawing from the service user accounts, one of the recommendations from the independent evaluation by a charity on the Collaborative Hub is integrating voluntary sector staff within a community mental health team. The research findings such as peer support and better access to housing provision, corroborate the implementation of this recommendation. All the participants agreed that using multi-professional teams, including the voluntary sector, is an essential means of resolving conflict that it will be crucial to the effectiveness of partnering to overcome disparities in the professional culture. For those considering integration initiatives, this is an important lesson: one person's integration is another person's fragmentation (Leutz, 1999). Therefore, the harmonisation of health, social care and voluntary sector staff will be a major factor in fostering positive health outcomes for the community.

As was discussed in the literature review, multidisciplinary staff working in the community and the integration of primary care services into community settings for mental health where adults with serious mental illness are found is increasingly evident in integrated care. Such community working addresses the issues related to access and whether the staff are trained to profile and plan care around individual health issues in a real-world setting (White et al., 2011; Scharf et al., 2016). The research borough has implemented this from the analysed local document 'Confederation Proposal' and it is confirmed in the year one independent evaluation report. Within *The Collaborative*, the staff are structured reflecting the primary care localities and moving the collaborative hub out into the local communities to offer initial conversations to people. A mixed method study by (Gradinger et al., 2020) on integrating the voluntary sector in personalised care found that a co-located and integrated voluntary sector partner can play an important part in the mature, transitional care model implemented across one locality within a wider integrated care system. Nevertheless, a comparable study could not be found of the impact of voluntary sector staff in integrated mental health care. The findings from this study would improve understanding of integrated mental health care, in addition to recognising the impact of social prescribing in peer support by voluntary sector staff on people with mental health conditions.

The previous literature has indicated that, for the benefit of service users, individuals of various professions and/or agencies needed to collaborate to deliver integrated health and/or social care (Pollard, Miers and Gilchrist, 2005). A literature review conducted during the discussion stage identified a study by Esponda et al. (2020) which illustrates that when proper resources, guidance, and supervisory systems are in place, non-specialists can perform some mental health treatments on primary health care platforms, even in low-resource, rural, and remote locations. This complements the findings of the current study concerning the contribution of voluntary sector staff.

The policy intentions of the local document 'Together Integrating and Transition Programme' are better population health outcomes, improved patient experience, delivery of person centred care at a lower cost per person, and improved experience of providing care as evidenced by mental health service users. The outcomes and the impact of the services as identified by the independent evaluation by the mental health charity confirms the implementation of the policy intentions as three services such as the collaborative hub, the collaborative network and the integrated alliance were created as part of *The Collaborative*. The assistance provided by the collaborative hub is depicted in the semi-structured interview findings chapter, section 6.2.1.1, and the hub assists people who had no prior access to assistance, as well as reducing the average cost per person and the number of referrals to secondary care teams. These aligned with the collaborative outcomes.

To secure availability of services, statutory and voluntary sector staff worked over and above their contracted hours and beyond their responsibilities or devised ad hoc solutions to the situation at hand. Lack of resources meant that the goals set by local policymakers, based on national legislation, could not all be achieved. According to statutory sector staff, voluntary sector staff were forced to take an active role to ensure that those facing a mental health crisis had access to the appropriate help. This finding supports several cross-national studies that examined the care workforce and showed that much of the stress experienced by professionals was caused by organisational and managerial factors, which professionals feel to be beyond their control (Cameron and Lart, 2003; Evans, Richmond and Shields, 2005). The effective teamworking and the collective leadership have enabled the development of cultures of high-quality, compassionate and continually improving care in the research borough. Having worked in other boroughs, some participants confirmed how progressive the research borough was as care was much more integrated than in other local areas, especially concerning accessing the services and provisions online during the COVID-19 pandemic.

8.3.2.1.1 Power Imbalance

Debates on the benefits of, and concerns about, the professionalisation of the peer support role are ongoing (Faulkner and Basset, 2012). The study questions the de-professionalisation of the social care and voluntary sector employees who are part of the integrated care system. Even though very few third-sector staff in this study were concerned that reciprocity might be lost if the role was over-formal, many felt that they should be treated as professionals in providing holistic, person-centred and coordinated care and support. In the international journal for social care, ‘Crossing the Cultural and Value Divide Between Health and Social Care’, Miller (2016) explains the decisions taken by management, and the stories and myths people tell and retell about their organisations, that the professional culture can be deeply ingrained and have a significant impact on the delivery of services. Although there were willing partners and leadership motivation, cultural challenges such as a lack of understanding of staff structures, data sharing, skill development, a lack of mutual respect, institutionalism, and service flexibility are highlighted in the focus group findings chapter under the 'differences in staff culture' section. In the research borough, the participants of the focus groups discussed the role of multidisciplinary team in overcoming professional divides, breaking down obstacles created by conflicting cultural and organisational disparities and offering the opportunity to provide comprehensive, ongoing, and seamless care.

In a similar way to Faulkner and Basset (2012), the findings of this study indicate social care professionals now do not have terms and conditions that reflect their professionalism. They are not employed or trained as professionals, and they are not treated as such, on the whole. The same applies to the voluntary sector staff. Furthermore, the goal of professionalisation is debatable. The study shows evidence that the voluntary sector staff and the care workers want to be formally accredited and respected as skilled professionals. Professionalisation is not a panacea for the problems of low-quality employment and the safety of services for users. More emphasis on education and skills cannot overcome harm to quality care by insufficient financing and poor salaries (House of Lords Economic Affairs Committee, 2019).

In some fields, there is reason to question if professional services always offer the best results for service users and their communities, which is further complicated by the intricacy of the discussion over role substitution. For example, the efficiency of peer assistance for mental health is growing (White et al., 2020; Mental Health Foundation, 2015). Most of the research participants argued that a fundamental professionalisation process with a key role for the voluntary sector staff, especially in peer support, was essential.

Interprofessional healthcare teams frequently involve different healthcare professions that represent the complexity of interdisciplinary cooperation. While earlier research studies have highlighted the benefits of such a healthcare strategy, a number of studies have also emphasised the barriers these interprofessional teams encounter in cooperating (Sarwar and Devlin, 2017). The effects of professional identity on interprofessional collaboration and professional interactions, which operate as a facilitator or a limitation, according to the circumstances, have been established by studies, Inter-professionalism has traditionally been synonymous with de-professionalisation, which challenges its professional authority and which might lead to the loss of professional knowledge among the individuals concerned (Sarwar and Devlin, 2017).

Partnerships and funding in the volunteer sector are being reviewed in the report (Department of Health Public Health England and NHS England, 2016), which is a one-year update from an NHS-backed review, The VCSE Health Review (2014). It was found that individuals in England confront severe health inequities, and these are typically addressed in novel ways by voluntary organisations, which build health and care plans with the people who use them. They would also garner more local support and be better value for money. This is asserted in this research based on findings from semi-structured interviews, where the transformative potential of the voluntary sector is harnessed and health and care services are co-conceived, resourced, and there is greater interaction with community groups that are close to the individuals who use them.

8.3.2.2 Underpinning Principles of Integrated Care

A major finding of this research was the fact that the underpinning principles of collaboration, peer support and empowerment have brought organisations together under *The Collaborative* to provide person-centred and outcome-based care for people with mental health conditions. Findings from the documentary analysis emphasise these principles, which include the most frequently identified underlying values of integrated care of ‘collaborative’, ‘co-ordinated’, ‘transparent’, ‘empowering’, ‘comprehensive’, ‘co-produced’ and ‘shared responsibility and accountability’, from a systematic literature review (Zonneveld et al., 2018). All the seven London borough documents analysed, highlighted the importance of collaboration and the documents ‘Joint working between Council and NHS’ and ‘Transforming Adult Mental Health Services and Support – The Collaborative’ explains how *The Collaborative* was implemented following the underlying principles. The leadership team highlighted that the services operated in silos and transferring service users from one commissioned service to another would result in an excessive number of assessments. The ‘Multidisciplinary Team Working’ section of the chapter on focus group findings reinforces the Collaborative Centre structure, which provides an integrated working environment with rapid access to clinical nurses, psychiatric nurses, and support workers all located in the same facility, considering integrating different sectors for example primary and secondary health care (Wadmann, 2009), that seeks to improve the quality of care for individual patients and service users by ensuring that services are well co-ordinated around their needs (Lloyd, 2005).

The interviews and the focus groups acknowledge that all members of the leadership team and the healthcare professionals interviewed were aware of the integrated care and they referred to it as collaboration, which is one of the underpinning principles. However, their involvement with it varied across professional disciplines. The leadership team confirmed that increased financial and service demands at the NHS could be addressed without restructuring the delivery of health and social care. The NHS Five Year Forward View plan published in 2014 (NHS England, 2014) outlines the ways provisions are to be transformed and stresses the need for better-integrated care (Shortell et al., 2015). *The Collaborative* created new integrated models of mental health services, with more community based services, redesigned acute hospitals and an improved commitment to preventative and public health (Ham and Murray, 2015). This was based upon the Convergent Care Theory (Wei, 2022), which encourages services to work-together to achieve optimal health outcomes.

The front-line staff, including the mental health nurses, care coordinators, support workers and social workers, described how integrated treatment techniques at the patient level resulted in improved patient satisfaction, reflecting the assessment by charities. Furthermore, the perspectives of care quality had been strengthened and accessibility enhanced. These reactions are comparable to the ones that have been recorded by Mason et al. (2015), who analysed eight electronic databases, relevant websites, review reference lists, and empirical studies to collect data on the forms of financing integration employed by schemes, their benefits and costs (including unintended consequences), and implementation hurdles. The participants reported building strong collaborative relations with individuals who served local patients with mental health difficulties as creating integration in inter-organisational health care procedures resulted in better person-centred service (Karlsson et al., 2020). An updated literature review during the discussion stage revealed the study by Soberay et al. (2021) in the US, where adults with SMI (N = 534) showed improvements in physical health and self-reported health after being involved in bidirectional integrated care. The evidence complements that from Breslau et al.'s (2017) study in New York state in the US, which examined a programme, that promoted the care provision at specialised mental health clinics to enhance the overall health of adults with severe mental illness by providing for persistent physical health problems. Similar to these studies, the findings of this study regarding *The Collaborative* suggest improvements in mental health for the service users, emphasised in the year three independent evaluation as the Hub provides comparatively low-cost, high volume support and the introduction of the Hub led to a statistically significant reduction in Assessment and Liaison Services and an average impact of around 44 referrals avoided per month. In addition, according to one service user in the third year evaluation, *The Collaborative* is offering a way of learning to support the recipient of the provisions.

In the current study borough, at the time of writing (January 2023), *The Collaborative* was in its thirteenth year in its journey to integrate mental health care services. The findings acknowledge that *The Collaborative* is still a long way from where it intended to be and have identified barriers to facilitating improved mental health outcomes. The focus groups findings confirm that one of the barriers for the front line staff is unclear communication and a lack of understanding of the structure of the teams and the roles and responsibilities of the team members. These challenges are confirmed in the study by Auschra (2018) on barriers to the 'Integration of Care in Inter-Organisational Settings': This is a literature review, where twenty types of barriers have been identified and then categorised in six groups such as barriers related to administration and regulation, barriers related to funding, barriers related to the inter-organisational domain, barriers related to the organisational domain, barriers related to service delivery, and barriers related to clinical practices.

The recommendations from the year two independent evaluation also include 'the need to more clearly communicate the Hub's remit and purpose in order to foster shared expectations amongst stakeholders' and 'the need to more fully understand differences in culture and practice between the locality teams that operate as part of the Hub – so as to ensure cross learning within the Hub itself.' Even so, change has been happening in integrated mental health care provision in the research borough. This testifies to the social constructionist insight that the social world is always being developed and reconstituted by reflective actors: the leadership team and the front line staff in the research borough.

One of the main findings of this research was peer support as an underlying principle, as endorsed by the participants, who acknowledge The Stone Center reference of mutual empowerment (Miller and Stiver, 1997). While solutions for peer support extend back several centuries, they have only evolved, developed, and became a vital component of the health system in the last few decades (Shalaby and Agyapong, 2020). Peer support in mental health is described by the Mental Health Foundation (2020) in the United Kingdom as the assistance and care that persons with lived experience of a mental illness or a learning disability may provide to each other. Mead, Hilton and Curtis (2001) noted the theoretical perspective of peer support and defined it as a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful, a theory adopted by *The Collaborative*. One of the local documents 'Confederation Proposal' enforces the peer support networks and it was implemented in the research borough as recommended by the year one evaluation by the charity. The semi-structured interviews findings from the current study reinforced that *The Collaborative* has enabled the space for peer support to develop in three different ways: a talking shop, a peer support hub and collaborative in crisis. The semi structured interview findings shared the talking shop evaluation with the service users in 2017, where 83 percent said they would definitely or probably suggest it to others, and 58 percent said the talking shop had benefitted their mental health. This finding supports the notion that adding peer support services to rigorous case management teams improves activation in terms of knowledge, abilities, confidence, and approaches for coordinating health and treatment. As a result of this support, patients are healthier, have a higher quality of life, participate in more health-related activities, and are more satisfied with their treatment (Chinman et al., 2016; Druss et al., 2010).

Adopting peer support services within mental health services is becoming increasingly popular across the world, and *The Collaborative* also provides acute hospital peer in-reach services, as accentuates by the leadership team in the semi-structured interviews findings chapter. The benefits of peer support services influence not just mental health service users but also peer support workers and the entire healthcare system (Shalaby and Agyapong, 2020), and the findings of the current study support this. The crisis line was highlighted by front-line personnel as an example of peer support provision, and the research borough is the only London borough during the study (December 2020) that provides this service. The service users reported that taking 20 to 30 minutes to get through their acute crisis made them feel better and enabled them to manage. It should be noted that the original literature review did not identify any research on the contribution of peer support in integrated mental health services and only a few research papers have investigated the benefit of peer support internationally (Shalaby and Agyapong, 2020; Chinman et al., 2016). The updated literature review confirmed the importance of peer support but it identified that nurses are cognizant of the potential challenges of successfully facilitating the integration of peer support workers in practice (Kilpatrick, Keeney and McCauley, 2017).

This study found that most local documents explained how empowering staff, service users and stakeholders can bring about integrated care to provide the outcome-based care in the research borough. Both semi structured interviews and focus groups participants confirmed that the evening support under *The Collaborative* empowers the service users as they reported an average of a 2-point increase in how they felt before attending the evening support and after, on a scale of 1-10. Moreover, the literature review describes how projects in Vietnam and Barcelona have provided important instruments for families and people with mental health concerns to manage and promote their own mental health on a daily basis (Murphy et al., 2017; Rojo Rodes, San Pío Tendero and Sanz Porras, 2016). Consequently, the findings of this study are congruent with those of Yotsidi and Kounenou (2018), who found that training programmes customised to the interests of service users were required for them to become less reliant on others and more empowered. As illustrated by the work of Elliott (2016), being in employment can help people with mental illnesses recover by increasing their self-esteem and confidence, as well as lowering psychological suffering. One focus group participant was a service user when s/he was introduced to *The Collaborative* and, according to the participants, her/his journey was an example of empowerment.

The local document, 'Transforming Adult Mental Health Services and Support – The Collaborative', refers to both service user empowerment and staff empowerment within *The Collaborative*. For both the leadership team and front-line staff, empowerment led to working closely with Healthwatch and CT to ensure growth in their abilities to engage with the borough's diverse communities. The participants contributed valuable reflections based on their professional backgrounds, reporting on implementing local policies from the documents in the documentary analysis, to address inequalities by providing housing, volunteering and employment opportunities for service users, thus providing access to them in policymaking and organisation building through peer support. Therefore, this study supports the empowering of individuals with mental illnesses by including them in planning and service delivery, even though such approaches are considered cutting-edge (Yotsidi and Kounenou, 2018).

The Collaborative has identified that when people are given hope and authority over their own life, they are more likely to recuperate, which contributes to empowerment. The findings on empowerment from the three phases, resonate with empowerment theory (Zimmerman, 2000) to empower individuals and communities to gain personal and interpersonal power to better their lives. This work also strives to challenge systems that hinder these groups from meeting their needs. To date, this initiative has yielded superior results, according to the three year independent evaluation summary, including the assistance of up to 400 patients every month, far before they reach crisis point, and a 43 percent decline in referrals to secondary care, resulting in shorter wait times. These findings support those of Crocker et al. (2020), who identified the possible metrics for evaluating the advantages of integration in terms of system impact, patient experiences, and medical outcomes. The collaborative commission's recovery college, according to the participants, offers a wide choice of courses and seminars aimed at helping people suffering from mental illness becoming specialists in their own recovery. Through the CT, Black service users are enabled to use their unique expertise to recruit, train, and achieve occupation to serve the diverse population through individual placement help and the recovery college. These underpinning principles of integrated care within *The Collaborative* have revealed improvements in user experience, front line staff experience and health and wellbeing outcomes and the impact of organisational culture in integrated care. The findings of this study are supported by a study by Saavedra et al. (2016), which emphasised that employment can be an important part of recovery from mental illness. However, individuals, especially those who have experienced severe mental illness, may require assistance with resources and knowledge to help them get back into work and bring structure to their lives.

The focus group participants also emphasised how front-line staff have progressive ideas about how to improve care. Fewer than a quarter of the front-line staff reported that they believed they were part of the decision-making process along with the leadership, empowering the staff and promoting an inclusive staff culture. Due to the limited number of front line staff in decision making, *The Collaborative* can follow only basic principles to maximise active participation from its staff to operate a dynamic outcomes management system (Koch, Cairns and Molly, 2000). These principles include articulating the value of the outcomes management system, involving clinical staff in its design, making it relevant to treatment goals. Thus assuring clinicians the system will not be used punitively, showing them how it will be used to improve treatment, by obtaining staff feedback routinely on how the system is working, and demonstrating how the organisational culture from top management down uses the outcomes information to make decisions.

More than three quarters of the front-line staff reported that they were not part of the decision-making process. This questions what actions have been taken to execute the suggestions in the Staff Engagement and Empowerment report by The King's Fund (2014) on enhancing NHS care by involving employees and devolving decision-making. Karlsson et al. (2020) investigated what constitutes a well-functioning inter-organisational collaboration in the provision of assistive equipment in Sweden. The findings revealed three interconnected processes: coordinating efforts to meet patient needs, guaranteeing evidence-based treatment, and planning for resource efficiency. The findings match those of *The Collaborative*, as both models illustrate that long-term cooperation is based on the deployment of administrative and managerial structures that foster connections between professionals, professions, institutions and procedures, resulting in better person-centred care.

8.3.2.3 Housing Provision

Policy documents have responded to improving the integration by addressing inequalities and addressing the shortage of housing. Following the national strategy, No Health Without

Mental Health (2011), the local documents 'Transforming Adult Mental Health Services and Support – The Collaborative' and 'Confederation Proposal' highlights social inequality of all kinds contributes to mental ill health, and, in turn, mental ill health can result in further inequality of worse outcomes in housing for people with mental health problems. These findings support those of the NHS Confederation (2022) report, which identified that for people living with serious mental illness, housing can be a critical factor in helping people to live as independently as possible, while also accessing the support they need to live and thrive in local communities. According to the semi structured interviews and focus groups findings, to resolve the issue, organisations collaborated with the voluntary sector organisations to address the housing shortages for the service users. Homeless Link (2014) reported 80 percent of homeless persons in England have mental health problems, with 45 percent having been diagnosed with a mental illness. Loubière et al., (2022) concluded higher housing stability, autonomy and lower use of hospital services for the homeless patients with severe mental illness with the Housing First, a recovery oriented approach and had limited effectiveness on recovery outcomes on a short-term basis compared to standard treatment.

The Client Satisfaction Questionnaire conducted as part of the independent evaluation of the Collaborative Hub confirmed that 11 percent of the participants of the questionnaire needed more help with housing. In this research, the leadership team and the front line staff reported that Integrated Alliance was implemented following the recommendation in the local document, 'Integrated Alliance – Adult Mental Health'. It is part of *The Collaborative* supporting people with serious long-term mental health issues to reduce inpatient rehabilitation bed-based services by moving people with long-term mental health disorders out of institutions and into specifically developed autonomous, community-based assisted living arrangements.

The outcomes of this study also corroborate elements of the findings of previous studies that were assessed in the literature review, including work by Stergiopoulos et al. (2015) in the US, which indicates that improvements in programs were observed over time on measures of community functioning, residential stability, hospitalisations, emergency department visits and community physician visits. Contrary to the current study findings, Lloyd-Evans et al. (2009) argue that solid conclusions can hardly be drawn concerning the clinical efficacy and economic effectiveness of alternative options to acute hospital-based standard mental health treatment. Alternatives to hospital admission have resulted in a 60 percent decrease in admittance to hospital rehabilitation wards in the research borough. According to semi structured interviews findings, Integrated Alliance's work has been reduced by 43 percent, a service that has been part of *The Collaborative* since 2015. In addition, sixty-nine percent of people have found more suitable accommodation, as they have left residential care for one of the integrated alliance schemes or have been discharged from inpatient care to their own home or supported accommodation. It also provided 19 percent with access to a personal budget that saves almost £2.5 million by exploring options to housing, hospitalisation and emergency care. This finding supports the report (Hampson, 2021) commissioned by housing and support services provider Look Ahead, which claimed that if integrated mental health and supported housing systems currently used in parts of London and the South East were implemented across the rest of the country, approximately £950 million could be saved to the NHS.

The findings in the literature review on ACT, which is not clinical intervention but a way to organise services to assist people with serious mental illness to integrate with their communities (DeLuca, Moser and Bond, 2008) showed the programme had been beneficial in treating adults with complicated health and housing needs on an individual basis. Furthermore, increased rates of self-contained stable housing, i.e., living in one's own house or apartment, and decreased rates of literal homelessness (i.e., living on the streets, in public spaces, cars and shelters) were recorded by ACT (Young et al., 2014).

The current study has identified community-based alternatives to inpatient care. The three year evaluation by the charity on service users and carers also confirms that people helped to participate on an equal footing in everyday life by helping to resolve benefits and housing problems, helping to find activities in the community, and obtaining personal health budgets, which also enhances personal choice. This finding corroborates the action on community based and socially inclusive approaches to mental health under the developed framework of the EU Joint Action on Mental Health and Wellbeing (Caldas, Mateus and Tomé , 2016). This work gave a special emphasis to the transition from institutional to community-based care for people with severe mental disorders and confirmed community mental health services have had a positive impact on the social inclusion of people with severe mental illness. In addition, results from the multi-country implementation and evaluation study (RECOVER-E) (Shields-Zeeman et al., 2020) will contribute to the growing evidence-base on the health and economic benefits of recovery-oriented and community-based service models for health systems in transition. Where possible, Integrated Alliance provides individualised help, such as personal assistants who can come to the person's house regularly. An ART, which is also implemented following the recommendation in the local document, 'Integrated Alliance – Adult Mental Health', is part of the Integrated Alliance, is an integrated team of voluntary sector staff, social workers, nurses, occupational therapists, and specialist psychiatrists who provide comprehensive assistance to people in their residences who would have formerly enlisted the help of a hospital. This indicates that residential alternatives to acute wards are well incorporated into local care networks and accommodate people with significant requirements and a history of mental health treatment (Johnson et al., 2018).

8.3.2.4 Digital Peer Support and Addressing Stigma during COVID-19

During the documentary analysis and semi structured interviews phases, COVID-19 wasn't in existence. However, four out of the five focus groups were conducted during the COVID-19 lockdown period and this study has revealed challenges and opportunities arising out of COVID-19 concerning mental health provisions. COVID-19's impact on mental health has become a topic of concern. Many factors linked to COVID-19 can have a negative impact on people's mental health, with those who are susceptible to psychological problems being at a significantly higher risk.

Those who already have poor mental health face a variety of dangers, including increasing rates of mental illness and disruptions to therapy, medicine, and support services (WHO World Mental Health Survey Consortium, 2020). Recent research indicates that COVID-19 is likely to accelerate pre-existing mental health symptoms or precipitate relapse in patients who already have a mental illness (Chatterjee, Barikar and Mukherjee, 2020). This complements the findings in the research borough as there was an increase of 800 percent in the calls compared to the previous year and many individuals were making contact for the first time in their life as they described having difficulties with their mental health.

Focus group participants confirmed that many services in this study have been forced to turn to remote mental health care, offering consultations using digital platforms or by addressing delays in mental healthcare by phone and providing digital peer support, according to the findings of this research. The study concurs with the research by Inkster and DMHDIG (2021), who collected information from digital providers based in more than 20 countries and it recognised the role of digital providers in delivering front-line services. The documentary analysis identified addressing stigma as one of the findings in order to achieve the collaborative outcomes in the research borough, for people with mental health issues by participating on an equal footing with others. Even though the three local documents, 'Transforming Adult Mental Health Services and Support – The Collaborative', 'Integrated Alliance – Adult Mental Health' and 'Confederation Proposal' proposed the need for reduced stigma, *The Collaborative* have implemented telephone or digital consultations only during COVID-19.

In the research borough, all the focus group participants agreed that the service users preferred telephone or digital consultations rather than face-to-face due to the stigma held by people in the community on learning about their mental health issues. This is acknowledged by Akbarialiabad (2021) in the recommendations for COVID-19 era and beyond, reporting that digital tools have the potential to ease barriers such as stigma by making mental health services accessible to all; more importantly to remote, needier, and vulnerable populations. One of the cultural characteristics fundamental to the delivery of continually improving, high-quality care is encouraging learning and innovation (The King's Fund and NHS Improvement, 2016). Sustaining cultures of high-quality care involves all staff focusing on continual learning and improvement of patient care. Learning and quality improvement are dependent on continual patient input – innovation is most likely where patients' views and feedback play a strong role, in recommending new ways of service provision by the service users. There appeared to be no studies examining this phenomenon and its implications for people with mental illnesses and those who care about them. Over half (N = 14) of the focus group participants acknowledged peer support was a 'secret weapon' in the fight against COVID-19 (Jadwisiak, 2020).

Work had been significant too, with the mental health being valued beyond economic advantages of employment. But there were inequalities: job loss was socio-economically patterned and some people were unable to remain digitally connected to continue their employment (Mental Health Foundation, 2020). All of this raised the risk of the pandemic worsening mental health disparities. During the pandemic, billions of people were gathering online to remain connected, but over half of the world's population did not have internet access. Front line staff from the focus groups reported the exposure of the digital divide, which impacted women more than men, and in the least developed countries, fewer than one in every five people had access to the internet (WeForum World Economic Forum, 2021). Human connectivity was needed to close the digital divide, according to 2025 Targets by the Broadband Commission (2020). Such gaps may have exacerbated mental health issues as the use of the internet and information technologies during the pandemic are key in facilitating proximity, closeness and communication.

Health staff redeployment was widespread and varied during the crisis. Some employees had been sent from their comparatively safe 'home' wards to high-risk sites (Dunn et al., 2020). Other staff members, who were at high risk or needed to be shielded, had been transferred off the wards to cover responsibilities to avoid personal communication. The current research reinforces these findings as many support workers and mental health nurses were redeployed to work in A and E and provide telephone and online consultation as opposed to face-to-face consultations. Over a third of nurses said their mental health was 'poor' or 'extremely bad' as a consequence of the COVID-19 outbreak, according to a recent study by the Nursing Times (2020), and the stress and anxiety of the front line staff in the research borough working in critical care during the pandemic was the same. The rapid review of the impact of COVID-19 on the mental health of healthcare workers (De Kock, 2021) confirmed the findings from the focus groups that organisations and their employees require support in dealing with anxiety. Furthermore, the findings of this study are in accordance with Wilson (2020), who explained how digital peer support had been developed to support the staff.

Half of the participants described advantages for redeployed employees, such as learning and development possibilities. Belonging to a team allows for peer support, social interaction, and consensus on the task and common working standards. Mental health practitioners were forced to provide personal physical care to patients, something which could elicit complicated emotions in the staff, such as incompetence, contempt, remorse, and embarrassment (O'Reilly et al., 2020). Due to the absence of interaction with familiar co-workers during the pandemic, employees were more prone to feeling alone when taking on new responsibilities. Various activities with *The Collaborative* were implemented to help the newly structured staff groups feel like they belonged to a team, including regular staff meetings, supervisory frameworks, and reflective practice. *The Collaborative* would assist the participants in adapting working patterns and developing morale in their newly formed teams, according to the participants. The pandemic would provide the opportunities to improve mental health care. The world's interconnection made society susceptible to the infection, but it also provided the framework for addressing earlier system failures by distributing best practices that could lead to long-term, economic, and inclusive mental healthcare delivery (Moreno et al., 2020).

8.3.2.5 Address Inequalities

The documentary analysis, semi structure interviews, focus groups findings and the three year independent evaluation of the Collaborative Hub revealed that the research borough had a variety of variables predisposing its population to mental health problems, such as a high level of deprivation, overpopulation and the possibility of homelessness. The documentary analysis of the research borough documents revealed that there were a variety of health inequities that pertained to mental health issues in the borough, such as the over-representation of Black mental health populations, and people with mental health problems facing stigma, discrimination, unemployment, and criminality. This was emphasised in Ngui et al.'s (2010) study, which stated there were inequities in mental health in access to treatment, use and care outcomes (e.g. morbidity and mortality) and they may emerge through reasons of geography (rural/urban), gender, socio-economic levels, race/ethnic history and sexual orientation. Considering the inequalities exist in the research borough, some of the values, which need to be addressed and improved for integrated care include comprehensive, accountability, continuous, evidence informed, equitable, sustainable and safe (Zonneveld et al., 2018). An international Delphi study towards a values framework for integrated health services (Zonneveld, Raab and Minkman, 2020) assessed the relevance of the values on the different levels of integration: personal level, professional level, management level and system level. The results provided insight into the relevance of these values on the personal level (e.g. ‘trustful’), professional level (e.g. ‘collaborative’), management level (e.g. ‘efficient’) and system level (e.g. ‘comprehensive’) of integration and it corroborates the research borough’s professional and management levels. Even though the three year evaluation of the Collaborative Hub of the service users and carers confirmed being trustful, improvements are required for *The Collaborative* to be comprehensive.

As the current study uses social constructionism as a theoretical framework, it is right to note that mental diseases are shaped in social and cultural contexts (Riel, 2016). That the socio-economic factors and the ethnic minorities’ culture influenced the mental illness in the research borough concurs with the statement from *Mental Health: Culture, Race, and Ethnicity* (Supplement) (2001: p5):

‘The cultures from which people hail affect all aspects of mental health and illness, including the types of stresses they confront, whether they seek help, what types of help they seek, what symptoms and concerns they bring to clinical attention, and what types of coping styles and social supports they possess.’

Reflecting on the documentary analysis findings, the phase two and phase three findings of this research explains the process of facilitating integrated care for mental health outcomes in the following sections of this chapter. The findings confirm that the collaborative outcomes address the inequalities related to mental health and these are the core building blocks for how the success was measured and determined. This is certainly relevant for the research borough’s specific goals, such as those set forth by the Ethnic Commission. The Ethnic Commission report, released in 2015, emphasised the necessity of co-producing services with service users and applauded *The Collaborative*'s efforts. The commission emphasised the importance of providing earlier and more accessible support as a strategy for reducing the disproportionate frequency of people from Black communities in crisis-orientated or coercive mental health care, like forensic services.

8.3.2.5.1 Recover and stay well, experiencing improved physical and mental health

Although there have been major policy issues in the UK since 2011 concerning parity between mental and physical health, discussions over relative esteem and provision of mental and physical health have lasted for a long time. It was a major feature of No Health without Mental Health (2011), a strategy that has been used by *The Collaborative*, the UK coalition government's mental health strategy. In its adoption of the Health and Social Care Act (2012), the NHS Constitution and the NHS Mandate for 2014-2015 have both been updated to cover particular references to mental health.

The documentary analysis highlighted integration and joined-up treatment, which could be accomplished using liaison psychiatry, non-profit organisations, and by training medical professionals and healthcare commissioners. The analysis of policy documents demonstrated that the most important aspect of equality was to treat all people affected by mental illness, whether they were patients, caregivers, healthcare professionals, or academics, with the same regard as persons affected by diabetes or cancer. People who had been diagnosed with serious mental illness lived 15 to 25 fewer years than those without, mostly due to avoidable physical ailments like heart disease and diabetes (Thornicroft, 2011). In the research borough, this statistic is confirmed by the stakeholders employed in leadership roles, who illustrated both the lack of parity and the disconnection between physical and mental health. The focus groups participants illustrated the person centred care by increasing whole person mental and physical health care and wellbeing support provided in the community. Additionally, the focus groups findings confirm working as a system to enable a minimum of 60 percent of people with severe mental illness receiving an annual physical health check and follow on support where this is identified.

The three year evaluation of the Collaborative Hub of the service users and carers reported challenging chronic physical health problems which compound service users' distress prior to receiving the support. One of the recommendations derived from the three year evaluation is co-ordinating a person's health across multiple conditions, benefitting both mental and physical health care. The Royal College of Nursing (2021) emphasised the necessity of coordinated efforts among several agencies, particularly for those with severe mental health conditions. It would assist people to offer knowledge and find out what works best to improve health results. This confirmed *The Collaborative*'s initiatives, but the leadership team have reported that there was no universally accepted method for measuring parity, either nationally (Baker and Gheera, 2020) or locally.

8.3.2.5.2 Participate on an equal footing in daily life

People who experience socio-economic disadvantages, such as unemployment, low income, poverty, debt, and inadequate housing, tend to be worse off psychologically (Silva, Loureiro and Cardoso, 2016; Platt, Stace and Morrissey, 2017). There is evidence linking greater socio-economic disparity with a higher rate of mental illness, and recessions have had a considerable impact on the mental health of the population (Pickett and Wilkinson, 2010; Platt, Stace and Morrissey, 2017; Wahlbeck and Mcdaid, 2012).

The research borough had the 38th highest (upper quartile) number of people estimated to have a common mental health condition in England, according to mental health and dementia focus pack tools (Public Health England, 2014). Furthermore, the working age population of the research borough is expected to grow by 9 percent in the next decade (Greater London Authority Housing Led Interim 2015 Base Projections), putting further demand on services and support. Six out of seven local documents analysed emphasised the ambition of *The Collaborative* to meet the collaborative outcomes, which partly address the holistic needs of people in relation to the wider determinants which impact on people's ability to lead a good life such as housing, work, education and relationships. The leadership team reported that in order to achieve the collaborative outcomes, the Collaborative Alliance was formed in 2015 following a prototype that started in 2013, providing people with open access to holistic support for a range of social as well as health issues, such as housing and employment support. Livingston, Jackson-Nevels and Reddy (2022) confirm the impact of poverty, income, housing, employment, health, social relationships, and education on individual well-being, which involves both physical and mental health as part of a holistic approach to health promotion and disease prevention.

When asked whether the prevalence of mental illness among the residents of the research borough remained among the highest in London, the semi structured interviews and focus groups participants confirmed that this was the case. Furthermore people who resided in the area were also dealing with a lack of decent housing and a lack of adequate employment prospects, which was affecting their ability to help those who had just emerged from the treatment system. The impressions are similar to the key findings from the national adult psychiatric morbidity survey of the mental health of people living in England (McManus et al., 2016). This study concluded that the majority of mental illnesses were present in those who lived alone, were poor in health, and who were unemployed. The local documents which were analysed emphasised the importance of personalised recovery packages of support for people with mental health conditions. The alliance contracting structure implemented within *The Collaborative*, offered customised and integrated services to the service users, according to the semi structured interviews findings. Supportive housing services and domiciliary care, as well as supported living services and supported employment services, were included in the Collaborative Alliance's comprehensive adult mental health services.

The research borough is 29th on the list of England's most deprived local authorities. Poverty and deprivation are key determinants of adult mental health (Cooper and Stewart, 2015). In the local authority, the documentary analysis findings confirm the statement ‘Societies with greater economic inequality appear to experience worse health and wellbeing than those that are more equal, not only for those at the bottom of the socio-economic ladder, but all the way up to the top.’ (Wilkinson and Pickett, 2010). Education has been proposed as the “great equalizer” that has and can continue to play a role in reducing inequality (Intell, 2018). Reflecting on the documentary analysis findings, both semi structured interviews and focus groups findings confirm education, training, volunteering or employment as one of the successes and achievements of *The Collaborative.* This is because Collaborative House, Collaborative recovery college and employment academy have employment experts, who have been trained to work with people with mental health issues, and they focus on helping people with training, volunteering and find and maintain employment using a person-centric approach. In the independent evaluation, the service users have confirmed receiving education and training to remain in or access employment and involvement in their local community or in an activity of their choice to reduce social isolation. Blundell et al. (2021) confirms that COVID-19 pandemic has affected inequalities in education, training, wages, employment and health and provide evidence of income inequalities between richer and poorer households, socio-economic inequalities in education and skills likely to have risen because of the crisis. As most of the focus groups were conducted during the pandemic, these findings corroborates with the research borough and there is more to do to support people with mental health conditions moving back into employment and education and parrticipate on an equal footing in daily life.

8.3.2.5.3 Culturally sensitive mental health care

The documentary analysis identified BAME communities being deprived of access to mental health support. Ethnic inequality in mental health had been a major concern in the United Kingdom for decades, yet there had been a gap between the execution of legislation and the methods used to accomplish them. Studies have found that the mental health care services that BME populations had access to were not always delivered in an appropriate manner (Memon et al., 2016). In the areas of mental health, BME communities were confronted with evidence of inequality every day, and this was not only referred to in official policy documents but was also recorded repeatedly (Grey et al., 2013). Recommendations were provided by the Independent Review of the Mental Health Act (Department of Health and Social Care, 2018) to help close the gaps in care, experience, and outcomes for people from minority ethnic communities, who seek support from mental health services. However, according to the consultation response by Royal College of Nursing (2021), members of minority ethnic communities were not specifically asked about their experiences during the government's recent follow-up consultation on reforming the Mental Health Act in England (Department of Health and Social Care, 2021). The follow up consultation contradicts the documentary analysis findings as four out of the seven local documents highlight the need to focus on racial inequalities in black communities in the research borough.

The semi-structured interviews evidenced the ethnic disparities and mental health. In accordance with the findings, since the arrival of the Windrush generation in the 1950s, the borough has been home to the UK's largest Black community. Many people of African and Caribbean ancestry have thrived in UK and made substantial contributions to the socioeconomic development. Despite the progress, inequities exist, especially among those of Caribbean descent, and this imbalance is most obvious in mental health and wellbeing in the research borough.

Furthermore, the focus groups findings chapter revealed the need to improve resilience, wellbeing and to reduce mental ill-health and stigma in Black communities in the research borough. As a result, through Collaborative Thrive, members of the local African and Black Caribbean community have greater accessibility on local and national matters in order to improve understanding and reduce stigma. The three year evaluation of the Collaborative Hub within the research borough made recommendations in working with socially excluded and minority communities.

Looking at the borough's primary qualities, it is densely inhabited, ethnically diverse, and 29th on the list of England's most deprived local authorities (Demographic Fact Sheet). Ethnic minorities get less mental healthcare than White patients (Thornton, 2020). The ethnicity statistics in the current study found that 47 percent of the users of the hub are White, while 35 percent are Black, (11.6 percent Black Caribbean, 11.6 percent Black African, 10 percent Black British, and 1.7 percent of other Black background). This finding contrasts with those of NHS Digital (2018) which shows that black people are more than ten times more likely to be given a community mental health/forensic treatment order than white people, such discrepancy could be the result of institutionalised racism and harmful stereotypes about black men's potential for violence and danger when they are mentally ill. Brown, (2021) reported that black men tend to enter mental health services through the police and criminal justice system, rather than the mental health pathway. The semi structured interview findings of the current study acknowledge the statement as the participants reported the death of a 40-year-old man with schizophrenia in 2008 after being subjected to police restraint and the establishment of a Collaborative Commission significantly impacted the mental health problems in the criminal justice system. Some recent assessments have emphasised the shortcomings of collaborative working between the police and health partners (NHS, London Ambulance Service), and the innovations developed as a response to support people living with mental health needs (Hobson, Grossmith and Dawson, 2015). The introduction of Street Triage in the research borough was partially designed to respond to elements of the action plans established through the Crisis Care Concordat in the area of mental health. It addressed, in particular, the provision of 24-hour access to professional services and encouraged partners to work together to achieve these objectives. The participants indicated that Metropolitan police officers should be in training alongside local mental health service users of Black African and Caribbean origin to manage and react appropriately to situations affecting them. The Mental Health Units (Use of Force) Act (2018), otherwise known as Seni's Law, demanded that mental health professionals maintained records of use of force and taught personnel the tactics of de-escalation, to limit the use of restraint.

National research has identified 15 times the variation in severe mental illness mainly psychotic disorders: the prevalence of schizophrenia and bipolar disorder in Black men standing at 3.1 percent, compared with White men at 0.2 percent (Mcmanus et al., 2009). Other research has indicated that the rate of incidence of Black populations (the number of new cases a year) is similarly higher. In 2012-2013, the Health and Social Care Information Centre reported that almost 42 percent of all White patients in England underwent some sort of restriction under the Mental Health Act; however, around 70 percent of Black patients were subject to a form of compulsory detention. According to the semi structured interviews findings, the current share of Black men in low and medium secure detention in the research borough is 67 percent and in high secure detention, it is 50 percent.

Three of the focus groups evidenced the responses from a BME focus group (January 2014) in the research borough in preparation for the Ethnic Commission. The responses were from mental health patients on what had stopped people from seeking help on mental health and it included fear of the system; fear of power loss; stigma; fear of institutionalisation; ego; the lack of an alternative service; perplexity, and anxiety. The findings suggest that *The Collaborative* has been trying to respond to such serious concerns in the Black community through CT. Its functions and structure are explained in Chapter 6, and in local communities, it is necessary to help with perceptions so that people have more confidence and are assured of access to services earlier, which prevents confrontation. Better involvement with individuals from BME communities in the creation and delivery of culturally specific mental health services could enhance awareness of mental health disorders and improve access (Memon et al., 2016) and that accords with *The Collaborative* and CT.

All three findings of the research suggest partnership working of the Collaborative Alliance with CT (a service specifically for Black communities), Health Watch, service users and carers should be used to initiate co-produced services that are more approachable, inclusive and equitable, accompanied by investment in a service that will reach out to all parts of the community. In implementing the policies to address cultural inequalities, the leadership team evidenced a Collaborative Thrive Shared Measurement System (SMS) being set up, and it monitored the working group in how it informed, developed or delivered activities that responded to the prevention agenda, as well as improving access and the experience of services for Black people in the research borough. It is one of the major and original findings of the research with possibilities for expansion into other areas of the UK as Baskin et al. (2021) concluded that there is a paucity of high-quality evidence regarding community-centred interventions that focus on improving public mental health among ethnic minority groups. Sheffield Hallam University has helped CT to create a baseline as an evaluation for the work of the partnership with *The Collaborative*. The evaluation has revealed that engagement from the community and the voluntary sector remained strong.

The semi-structured interviews findings demonstrated an event hosted by Collaborative Thrive in February 2019 in collaboration with a charity to discuss data on the inequalities experienced by Black communities across a range of statutory services in the London borough. Over 100 attendees shared their lived experiences and recommendations for change with system executives. This provided context for various aspects of the partnership's work, suggesting areas that require additional inquiry as well as places where systemic change is required. Moreover the focus group results confirmed how the Collaborative Alliance was engaging with other health institutions and the local community to promote mental health stability in the borough. Following the three year evaluation recommendation, these findings share *The Collaborative*'s and the Collaborative Alliance's attempt to minimise the over-representation of Black ethnic groups in acute mental health services and tackle the inequities encountered by people with mental health problems, as it has the potential to effectively and sustainably reduce social and racial inequalities in mental health outcomes (Public Health England, 2019; Davies and Department of Health, 2014). In addition, the research findings emphasise that improvements have been made within the London borough, but it seems clear that there remains a sustained need for government departments and mental health agencies to address the many challenging issues that exist between Black communities, criminal justice, and psychiatry. Since the criminal justice system can serve as a gateway to the mental health system and vice versa, the implementation of comprehensive reforms to improve both systems are even more urgently needed.

Even though *The Collaborative* has stronger outcomes with the BAME communities, there is a clear evidence of the proportion of White British against BAME participants, as 80 percent of the semi-structured interview participants were White British and 80 percent of the participants of the front-line staff were from BAME communities. *The Collaborative* must commit to equal opportunities, removing a racial hierarchy in the workplace, confirmed by Lowe (2013) in 'Keeping Leadership White: Invisible Blocks to Black Leadership and Its Denial in White Organizations' and The King's Fund (2018) in 'Closing the gap on BME representation in NHS leadership: not rocket science'.

8.3.2.5.4 Stigma

Stigma, as a marked and labelled difference, allows for multiple forms of discrimination that, as Goffman notes, eventually deny the individual or group's right to complete social acceptance, diminish individual opportunities (Goffman, 1963), and exacerbate societal disparities (Parker and Aggleton, 2003). Social interactions, resource availability, stress, and psychological and behavioural responses are just few of the many processes that stigma can exacerbate to negatively impact population health outcomes (Stangl et al., 2019). Five out of the seven local documents analysed recommended the policy intentions of achieving the collaborative outcomes. One of the collaborative outcomes is for people to participate in everyday life on an equitable basis, in particular with regard to education, jobs, appropriate earnings and secure living, and to tackle stigma and discrimination.

Drawing on Goffman (1963)'s stigma status framework, data from the semi structured interviews found that recommendations from the Collaborative Commission and the priorities of CT is to eliminate the stigma associated with mental illness and enhance mental health knowledge and understanding. Raising awareness, offering education programmes, lobbying, and social interaction were the most typical techniques adopted by programmes to address stigma, either directly as a primary outcome or indirectly as an expected by-product of other actions.

This has resonance with the findings from the study by Stuart (2016) on anti-stigma programming using examples from different countries to understand and describe current best practices in the field. Agreeing with these common approaches, both semi structured interviews and focus groups findings of this research reveal that the Collaborative Alliance fosters links across local communities and with other organisations, such as those involved in public health and primary care. There is a growing emphasis on mental health prevention and building individual and community resilience. *The Collaborative* worked to reduce the stigma and discrimination associated with mental health difficulties, to increase the understanding of mental wellbeing and how to remain healthy, and to raise knowledge of resources available to people in the research borough. This finding agrees with those of (Kearns et al., 2018) as it reported that both public and self-stigma were significantly lower, and attitudes towards seeking professional help significantly more positive, after community-based mental health services had been introduced.

Furthermore, as mentioned in the literature review, the study by Meyer-Kalos et al. (2017) on service users found stigma as one of the barriers to integration (Graham et al., 2013) and recognised that to achieve a more balanced viewpoint, future studies should assess client approaches of health and wellness. This is in line with the belief that stigmatising sentiments toward people with mental health disorders are ubiquitous and widely held when it comes to social stigma (Crisp et al., 2000). Although there are many studies related to mental health, research with a focus on stigma in mental health remains limited.

There are a number of critical enablers that might be used to assist in the delivery of services and the achievement of mental health outcomes to eliminate stigma. The Collaborative Alliance has driven the implementation of key enablers across the system. It is important to emphasise that pre-COVID-19 and during it, the potential for digital platforms and technology to dramatically revolutionise the way mental health support is offered, managed and is made accessible was highlighted. Digital remedies that were delivered directly to users had a lot of potential as public health interventions

(Fairburn and Patel, 2014; Muñoz et al., 2016). If they are accessed directly over the internet, they have a huge potential reach and may be able to overcome many of the barriers to receiving help, such as stigma, shame, a lack of local treatment facilities, and expense (Muñoz et al., 2016), while acknowledging that there will be some inequalities of access. Even though the Collaborative Alliance identified pre-COVID-19 that digital tools could provide easier and faster access to help for service users, on their own terms and from the comfort of their own homes, nevertheless, the measurers were only deployed during the pandemic, not earlier.

According to modified labeling theory, people also internalise negative public attitudes, leading to demoralisation and maladaptive coping efforts (e.g., social withdrawal). Therefore, beyond the debilitating effects of symptoms and direct discrimination, internalised (self) stigma leads to constricted social networks and diminished well-being, inhibiting prospects for recovery (Markowitz and Engelman, 2017). To address this, empowering the service users and local communities and developing positive relationships with local communities were the key steps taken within the research borough. In earlier studies, men were found to be less likely than women to seek assistance for prevailing mental health issues, and more likely to have a negative attitude toward seeking assistance (Lubian et al., 2021). The challenge of young Black men obtaining primary care mental health services had been recognised in the study borough. The findings from the focus groups with frontline staff highlighted the strategies employed by *The Collaborative*, such as bringing the services to the patient, that aimed to resolve perceived power inequalities. The findings also emphasised having access to a physician who was not dressed professionally allowed group members to begin building more trusting connections with the physician and, as a result, with the services.

The national anti-stigma campaign Time to Change was evaluated and shown to have improved social perceptions and stigma-related information over time (Henderson et al., 2012). However, the same benefits were not noticed in BAME groups, at least at first (Time to Change, 2010) and is confirmed by the local documents when making recommendations for the black communities and the phase 2 and phase 3 findings of the research borough. The participants confirmed that after starting the Collaborative Commission, the collaboration of the commission with the Time to Change campaign had provided increased mental health awareness and education. Collaborative services had promoted continued development to combat stigma and discrimination in mental health through community-building as co-production, and community ownership processes lead to increased trust in workers and demands for services, provided that the initiative raised awareness of mental health and reduced stigma (Codjoe et al., 2021).

8.4 Chapter Summary

This exploratory study has achieved its purpose of policy analysis and uncovering the views of the leadership team and the front-line staff and their role in impacting the mental health of the population in one London borough, based on the preceding findings. These findings, in connection with the previous literature and the three year independent evaluation of the Collaborative Hub by a charity, have been discussed, as has the potential for implementation in other areas in the UK. This knowledge aims to educate readers on the importance of integrated care in mental health provision and the role of *The Collaborative* in enhancing people's wellbeing.

First, there is the role of voluntary sector organisations attempting to address the inequalities and provide person-centred and outcome-based care for people with mental health conditions, as they are the closest to people who use them. Second the underpinning principles of collaboration, peer support and empowerment have brought the five organisations together and the multidisciplinary teams have achieved better access to housing for the service users, as presented in the Housing Provision section in this chapter. Third, it has been revealed that the collaborative policies, leadership team and the front-line staff recognise that inequalities, such as parity of esteem, socio-economic factors, cultural sensitivity and stigma continue to hamper access to mental health services and the seeking of psychological support, but the constantly evolving *The Collaborative* is attempting to overcome those barriers to achieve the required outcomes. Fourth, the interviewees revealed how committed they were and they believed they were making a positive difference to extremely vulnerable people in their community during COVID-19 through digital peer support. It is important to note the fact that the findings need to be approached with caution because four out of five focus groups were conducted online and the findings were formulated and interpreted during the global pandemic. This research shares what has worked well and what barriers still exist. It is important to appreciate the limitation of being unable to fully comprehend how well it has worked or not during the COVID-19 period or how these methods may be transferred post-COVID-19.

The core of *The Collaborative* has been to identify and agree upon the results from services that are most relevant to patients and service users and identify and agree upon the best available specific measurements of the most important outcomes. The evaluation has demonstrated that people are satisfied with support the Collaborative Hub has offered, that this support meets some of their needs and helps them deal with their problems more efficiently. While the participants realise that *The Collaborative* is still a long way from its destination, they feel that some significant lessons have been learnt that may enable others to impact mental health and beyond. This has, of course, not been easily achieved.

Collaboration necessitates a significant investment of time and trust, as well as a willingness to let go of old habits. Even more challenging, it necessitates that all stakeholders put their short-term organisational interests aside, offer strong leadership, and engage in painful dialogues. The theoretical framework of social constructionism has provided a conceptual space to see the social world from multiple angles: it was an invitation to use documentary analysis, semi-structured interviews and focus groups to interrogate social phenomena. In this case study, the leadership team and the front-line staff expressed views in the semi-structured interviews and focus groups that the integrated care in the London borough was progressive compared to other areas in London.

CHAPTER 9: CONCLUSION

9.1 Overview

The use of case study methodology has provided a more comprehensive knowledge of how integrated health and social care is applied in mental health practice. The main research question *How has The Collaborative facilitated the integrated care process for mental health outcomes in one London Borough?* has been examined from multiple perspectives. Using a social constructionist method to develop a deep knowledge has been beneficial in getting insight into this difficult topic. The research's primary findings, as well as the research's strengths and limitations, are outlined in the conclusions, which can be used locally and more generally to inform the implementation of integrated care in mental health practice. It also includes a review of the ways in which this research contributes to the existing body of knowledge, as well as onward recommendations and suggestions for future research. In addition, building on my experience as a cultural insider and a researcher, I share reflections on the research process. To accomplish this, I concentrate on the journey's professional and personal repercussions. Finally, the study's ramifications are explored in terms of mental health education and clinical practice, community, and mental health care service organisation, as well as policy development. This will provide insights into problems and solutions around inter-organisational and interprofessional working that will guide the planning of the integration of mental health care in the future.

9.2 Summary of the Findings

In this study, the findings showed that growing financial and service pressures in the UK NHS cannot be tackled without transforming how health and social care are delivered. National and local policy is driving change throughout mental health services in England and the case borough. *The Collaborative*, the partnership of five partner organisations, the Council, CCG, the Commissioner, which is an NHS foundation trust and two charities, have shown that working together, taking a holistic approach and harnessing all the expertise can help provide early support and quick assessment when needed. In addition, it can improve the lives of those with mental health conditions. It is clear all the changes adopted for implementing *The Collaborative* were linked to policy objectives related to shifting the focus from treatment to prevention, reducing reliance on hospital care and improving the financial viability of the health service.

The VCS organisations and staff have provided leadership in developing recovery-orientated approaches. Also, they offer an alternative, and potentially complementary, adjunct to statutory crisis provision through providing a non-medical response that focuses on person-centred and outcome-based care for people with mental health conditions. The underpinning principles of collaboration, peer support and empowerment have brought the five partner organisations together and the multidisciplinary team have achieved better access to housing for service users. The findings of this study indicate barriers like parity of esteem, socio-economic factors, ethnic minorities and stigma, which may inform and influence further improvement and future local and national policy through *The Collaborative*. In addition, the interviewees revealed how committed they are and they perceived they were making a positive difference to extremely vulnerable people in their community, pre-COVID-19. During COVID-19, digital peer support has helped in addressing stigma.

The study explored how *The Collaborative* has been developed, implemented and sustained, and how it has impacted the wider system context. It has presented robust evidence of improvements on several service and patient outcomes and these findings have been central to their wider impacts, shaping local authority level and country-wide integrated care policies. However, the wider dissemination of projects occurred in an incremental and somewhat haphazard way. To further redesign health and social care, a more formal strategy, alongside resources, may thus be needed to provide funders and providers with genuine incentives to invest in new business models of care. There remains the need for a better understanding of specific local conditions that influence implementation and sustainability to enable translation to other contexts and settings.

9.3 Original Contributions to Knowledge and Strengths

The purpose of this study was to explore and examine the integrated working within *The Collaborative*, which was introduced to improve the mental health and wellbeing of people in one London borough. This will add to the growing body of knowledge about integrated care and mental health provisions from the leadership team and front-line staff's perspective, which is important for greater public understanding of *The Collaborative* and possible policy development.

Previous research has documented the integrated mental health care systems by prioritising physical health and behavioural health, predominantly in the US (Wright-Berryman and Kim, 2016; Meyer-Kalos et al., 2017), with the exception of one study in the UK (Miller, Rees and Buckingham, 2014). Miller, Rees and Buckingham (2014) aimed at investigating how commissioning is implemented in the mental health of adults and the extent to which a fresh strategy to mental health planning and provision has been developed. In addition, integrating mental health into primary care, self-management of mental illness and the contribution of the multidisciplinary team have been well documented in the literature and exploring the integrated care system facilitating improved outcomes in mental health is believed to be imperative. As noted in the literature review, integrated mental health research is limited worldwide and in the UK, and evidence suggests the rhetoric of or reality gap in health and social care integration practice (Baxter et al., 2018), and this has particular implications for people with serious mental health problems (Panday, 2016). Results demonstrate evidence of improvements in many service and patient outcomes; particularly voluntary sector contributions and housing services. These findings have been central to their wider impacts, shaping local authority-level and country-wide integrated care policies. With the growing importance of integrated care in the UK and the world and the importance of addressing the unmet mental health needs during COVID-19, this research has provided a contextualisation of inter-organisational and interprofessional working that will guide those planning integrations of mental health care in the future. Past research about integrated mental health lacked evidence of services, and this case study has illustrated how integrated mental health provisions have been applied in one London borough.

In addition, the study's participants were recruited from various backgrounds, including commissioners and directors, who set the policies, and the front-line staff, such as mental health nurses, psychiatric nurses, care coordinators and occupational therapists. The literature review confirms the lack of research studies in an integrated mental health system with the leadership team as participants. Therefore, an advantage lies in obtaining feedback from *The Collaborative* leadership in the formulation of strategies to benefit the overall mental health services in the UK by developing a toolkit and addressing concerns relating to integrated care as well as shedding light on this issue. This is particularly so in terms of the role of the leadership team who are the policy developers and decision-makers for people with mental health conditions.

The policy document analysis and the semi-structured interviews with the leadership team elaborate how national and local policies were implemented in the London borough. Since little work was conducted before in the policy document analysis of integrated care and mental health policies, this is one of the strengths of this paper. In addition, the themes that emerged from the policy document analysis were discussed with the leadership during the semi-structured interviews and they confirmed that the themes aligned with *The Collaborative*'s priorities and strategy. This meant member checking was used to improve reliability.

As the authors of the case study approach have indicated, their strengths are their ability to examine 'phenomena as they occur or exist in real-life contexts' (Chen, Chiang and Storey, 2012). Case study as a methodology explores and critiques a phenomenon in context by using multiple data sources and collection methods (Baxter and Jack, 2015); the current research uses documentary analysis, semi-structured interviews and focus groups. To understand complex social situations, it is important to experience them yourself or learn from the experiences of others (Harland, 2014). Although *The Collaborative* had been in place for over 10 years, there was a lack of depth in what was known about the different programmes in place, the expectations of the leadership team and the front-line staff, and how the initiative has facilitated the integrated care process for mental health outcomes for the service users.

The focus of this study was on the qualitative interpretive approach. This is about why things happen in 'particular ways', where lived phenomena reflect 'lived experiences' and the 'perceptions of the world' of people. This led to the application of semi-structured interviews and focus group discussions that allowed the consideration of human preferences and trends. Through an interpretive perspective, it is feasible to determine how motivation, dialogue and human perception aid the causal explanations of social reality and, therefore, the phrase 'comprising human action in context' has been extended beyond the boundary of its original meaning (Willis, 2007).

The analysis of the discussions identified the experiences of the leadership team in integrated mental health care, many of which have not been covered in the literature to date in a UK context, including the impact of stigma on personal and professional relations and mental health services.

The use of social constructionism is another quality of this study. Burr (2015) suggests that the typical ways to perceive a notion originate from the way people construct it between themselves, i.e., by the perceptions of the leadership team and front-line employees. Social constructionism means that the process of learning includes interactions in social contexts, i.e., learning involves many people and takes place during social interactions among people. Some buildings are thus interconnected, and some compete. Individuals cannot stand outside or beyond society; instead, they become caught up in social processes, even when they are sometimes unaware of these interactions. The thesis demonstrates that different constructions formed by the leadership team and the front-line staff have the same implications from the meanings of particular social constructions, and that each of these has likely consequences on the mental health of the service users. Using NVivo 11 for coding and analysis is another strength.

Additionally, the literature review of this study noted the lack of knowledge on the contribution of the voluntary sector. This study has, therefore, provided an important contribution to the knowledge base by exploring the role of the voluntary sector organisations and staff in the London borough. Tied in with this role is the process of recovery. Again, an important contribution made by this research is that it offers a critical engagement of recovery as a process, demonstrating the key mechanisms by which it is promoted and facilitated. As previously highlighted, a rigorous analysis of what the process entails has been lacking (Rudnick, 2014). There also remains the absence of information in the general literature about the role of voluntary organisations in relation to recovery, making the findings from this study original and valuable. Finally, the role and benefits of voluntary organisations have been identified in the context of social capital. This was particularly valuable given that the knowledge base remains limited on the relationship between social capital and mental health. The findings from this study have shown the way in which social capital connects service users to each other and their local communities. Given the interest in social capital in mental health policy, these findings are valuable. Currently, amid the context of recession and austerity and the pandemic (Nottingham Trent University and Sheffield Hallam University, 2021), several voluntary sector organisations are experiencing rising demands for sector services (Jones et al., 2016). This has resulted in a sector of strongly tested resilience that is quickly pressured to restructure and reposition itself in a financial situation that is becoming increasingly challenging. In this context, many participants gave rich descriptions of the service users and the systems in place, and were, thus, able to construct their own theories and hypotheses to make sense of the experiences. Qualitative research can capture changing attitudes and provide a much more flexible approach.

Another strength is that qualitative research can be more targeted; in this research, specific groups are sampled and key points of *The Collaborative* are examined to gather meaningful data. An interview guide with open-ended questions provided participants with platforms to address their experiences with treatments. In addition, the study was strengthened by the use of triangulation, noted by Holtzhausen (2001) to be a powerful tool to strengthen the qualitative research design. The triangulation in the current research is described in the methods section in the Methodology chapter.

9.4 Limitations and Future Research

This research has been based on the assumption that integrated care is used in mental health services, but the utilisation and effectiveness of these services are less well known. Healthcare providers, according to Judge and Bauld (2001), are required to understand the evidence base for such changes, and to know as much as possible about complicated therapies and how they work, on several levels. Using a case study technique that spanned methodological boundaries, this case study has attempted to gain additional knowledge regarding integrated mental health care. A single borough was researched in depth from many angles based on the methodology used and a qualitative approach. Taking Judge and Bauld's pragmatic view that all research methods have advantages and disadvantages, qualitative approaches and the triangulation of their products were seen as the best way to learn about *The Collaborative* as a complex phenomenon.

Understanding cause and effect, as well as the pressure of scientific review, subsided beneath the desire to learn more about this one London borough endeavour. This study can be seen as trustworthy if it is based on the assumption that generalisations do not always rely on representation for validity (Sharp, 1998). However, the potential limitations and objections of empirical generalisation are acknowledged in this direction. The most important of these is the difficulty of generalisation, despite the fact that Hodkinson and Hodkinson (2001) and others offer compelling arguments for how the theory might be used outside the limits of a case study. While Stake (1995) points out that case studies may appear to be a weak foundation for generalisation, there are likely to be generalisations within a case when a topic is examined in sufficient depth. The high-level stages of a patient experience, for example, are described equally by the leadership team and front-line workers in this study. The documentary analysis adds to this information, allowing for a more refined generalisation of how *The Collaborative* is understood from many perspectives.

Furthermore, reporting of the accounts of people who are driven to participate in the study may be misrepresented in many ways. For instance, to request funding applications, the participants may have highlighted in their interviews the practical demands of the programme in the London borough. Additionally, the findings imply that ethnic minority groups are reluctant to seek assistance because of the stigma but, conversely, they also indicate a tremendous desire for culturally specific treatment for mental health. In this respect, further research is needed.

In the same way, while the partner organisations offer daily care and assistance in *The Collaborative*, they are not the only suppliers of mental health services in the borough of London under study. Psychological and mental health providers outside *The Collaborative*, such as other charities, may need their perceptions to be included among the mental health services. Such inclusion is designed to help understand the needs of the population in mental health and to respond to the requirements of professionals working in it.

Using Atkins and Sampson (2002) and Yin's (2003) view of an exemplary case study as a foundation for a critique of this study, it may be argued that this case is of little significance - yet this would be contrary to the literary review. The limits of earlier research show that papers lack specifics on context, techniques or analyses where studies have taken place. In the methodology, these restrictions have been overcome. This case is distinguished by a circumstance that complements the current body of knowledge. Detail, depth and triangulation have been offered in the methodology to tackle the challenges of sample size (Begley, 1996; Shih, 1998).

A variety of sample issues need to be taken into account. The sample size for this study could be regarded as being insufficient and not adequate to provide readers with an overview of the role of *The Collaborative,* and the way they feel about meeting the demands of mental health. Additionally, the use of the purposive sampling may have risked a biased sample and a low level of reliability. This has been considered as the professionals who were willing to volunteer may have been skewed towards a particular view compared to those who did not participate. The sample size was limited by time and words in this study. In addition, the objective aim of this study was to explore and examine and gather in-depth data. Furthermore, the recruitment criteria for the semi-structured interviews only included the leadership team, who had been part of *The Collaborative* for over three years, inclusive of two participants with two years of experience. Thus, the sample may not be representative of people who have started to provide assistance for the provision of mental health relatively recently; such participants may have yielded a very different set of data.

Taking the modest sample size of the qualitative phase participants into account (13 in the semi-structured interviews phase and 20 in the five focus group discussions), and since the data is from a comfortable sample, these study findings are not generalisable to other mental health teams in larger boroughs. During the qualitative approach, the participants were carefully selected with the cooperation of a gatekeeper and the heads of the four collaborative services of *The Collaborative*; therefore, the opinions expressed by the research participants cannot reflect the perceptions of all mental health teams in the borough. Another limitation in the research is the proportion of White British against BAME participants. In the research borough, 60 percent of the population, i.e., 3 in 5, describe their ethnicity as other than White British: 24 percent are Black, and almost half of these, 11 percent, are Black African. This is not reflected in the sample of the semi-structured interview participants as 80 percent of the leadership team participants were White British while 80 percent of the participants of the front-line staff were from BAME communities. This reveals the underlying issue of a lack of BAME's in the leadership roles within *The Collaborative*. Considering this limitation, conducting future research on how Collaborative Thrive has facilitated improved mental health for BAME communities is important and will add to the literature. Moreover, this work cannot be generalised to the entire city of London or the UK population because the study was design-exploratory, and the demographics of the other areas are different.

The absence of information from service users is another limitation. The literature argues that health and social care reforms have the greatest influence on service users but the views of this group on the effect of integrated work is rarely recognised (Dickson et al., 2009). The studies reviewed for the purposes of this research recruited predominantly service users suffering from poor mental health, but there was limited research on integrated care with service users as participants. In the research borough, the three-year evaluation of the CH conducted by a charity explained that the data was collected to explore experiences of service users of *The Collaborative*: i.e., via PPI (patient and public involvement). The three-year evaluation was started in January 2016 and completed in December 2018 and after each year, reports were produced. The reports provide background of the service users, their challenges, the activities they prefer, the support they received from *The Collaborative*, their experiences with it, their life when they left *The Collaborative* and their future aspirations. Some of the staff of *The Collaborative* were also service users themselves and shared the data from both a service user and a staff member perspective. Future work could explore the impact of *The Collaborative* on service users to evaluate both their perceptions and how well their requirements have been met when the service closed their case.

Low response rates from the statutory sector front line staff were a limitation for the focus group. It meant that responses from these groups (psychiatric nurses, mental health nurses, care coordinators and occupational therapists) had to be merged to meet the requirements for analysis. Future research could explore the perspectives of more statutory sector front line employees to understand whether more perspectives from statutory sector staff have an impact on integrated working within *The Collaborative*.

A final limitation is the challenges encountered in data collection during COVID-19. Even though extra effort was made to minimise the exclusion of participants, due to their lack of digital literacy and access to digital technologies or because of self-isolation or because of suffering from the illness, this research has inadvertently reinforced existing inequalities and the experience of marginalised groups. As a result of the lockdowns and restrictions caused by the pandemic, a variety of ethical issues have arisen, including consent, focus group recruitment and setting, and risk management.

When it was difficult to collect a physical signature or discuss the procedures face-to-face, obtaining informed written consent via remote technologies was a challenge. To overcome this, consent forms were sent, discussed at the focus groups and returned via email. The consent form was also updated to reflect that the focus groups would be conducted and recorded online using university-authorised technology, such as Microsoft Teams.

Remote participation in online research has been observed to distort the participants' knowledge of the environment, causing them to ‘forget' the study context in which the dialogue is taking place in some cases, particularly when people are at home. While this offers increased accessibility, equity in participant contributions, lower costs and rich data gathering opportunities (Reñosa et al., 2021), there were challenges for some participants, such as those who were sharing their home with their family and all the family members were at home during the lockdown. In the invitation email to the participants, it was made clear that the focus groups would be conducted and recorded online using university-authorised technology such as Microsoft Teams and the meeting would be password protected. In addition, at least one of the supervisors was present at each virtual focus group to observe to confirm that there were no online distractions while the focus group was taking place. If the participants were staying at home due to the COVID-19 situation, they were asked to ensure that there was privacy when they were taking part in the focus group. Also, they were asked to ensure that the internet connection was good and the video, speaker and microphone were in proper working condition. In the case of a connection drop off for one of the participants, a decision was made to cancel the whole focus group and reschedule it, but this was not experienced in reality.

It was critical to this study's success, especially given these health conditions, to ensure that the researcher kept themselves and their participants safe, did not take excessive risks, and did not make anyone feel obliged to do so. There was a robust participatory risk management approach in place that included everyone's viewpoints, not just the researcher's. It was communicated to the participants through the gatekeeper. All these limitations were addressed, outlined and submitted to the University’s ethics committee during the ethical clearance process for approval.

9.5 The Insider and Outsider Perspective – Personal Reflections and Methodological Considerations

The impacts of participation in this study, as well as the learning gained, were essential factors in the research. The planning and collection of participant data took place as part of a process that began early in the research when the proposal was written and ethical approval was sought. According to Devers and Frankel (2000), when conducting a study, the researcher must be self-cognizant. This is especially true if the researcher works for a mental health organisation. This is particularly applicable where the researcher represents a mental health charity. There was limited knowledge or experience at the outset on integrated mental health systems, despite my knowledge of the integration of health and social care from being the Chair of Health and Wellbeing Board in a London borough, but not in the research borough, and setting up a mental health charity. My position as the Chair of a Health and Wellbeing Board in a London borough and setting up a registered mental health charity would place me as an insider in the research borough. As I only met the Chair of the Health and Wellbeing Board of the research borough immediately before starting my research, I also had a new 'outsider' status. This section of the chapter takes into account this dual view and the consequences this had on my collection of data.

Corbin and Strauss (2008) claim that data sensitivity can be improved as a result of experience in the field, but the researcher must ensure that the data acquired speaks for itself and is not merely insider knowledge. '*It is not the researcher's view of an event that matters*,' say Corbin and Strauss (2008: p33), but '*experience provides a comparable ground'* (2008: p34). A researcher who examines their own kind — that is, a person who examines a cultural group to which they belong – is known as an ‘insider’(Maanen, 2006). One of the priorities of the Health and Wellbeing Board was the integration of health and social care. Being the chair of such a board enabled me to visit Greater Manchester to learn about their integrated care system, and New York to learn about their DSRIP (Delivery System Reform Incentive Payment) system. I had never worked or had any connection with the research borough prior to starting my research, so it is debatable to what extent I was still considered an insider.

In particular, with regards to the monthly breakfast meeting and the leadership team and the front line staff in *The Collaborative*, I have been welcomed into the research environment. My research was to place *The Collaborative* at the centre of a study, the results of which would be seen by other London boroughs who might want to implement integrated mental health care systems. I also had the status of outsider. An outsider is described as an individual researching a group that s/he does not belong to, nor has s/he been associated with (Hammersley and Atkinson, 2010). Since I have never worked or had any connection with the research borough, I could also be classified as an outsider. Researchers considered as insiders have been traditionally more warmly received than researchers viewed as total outsiders (Simmons, 2007; Suen, 2010; Baumbusch, 2011). I was introduced to the monthly breakfast meetings, the leadership team and some of the front line staff through a gatekeeper, and they appeared to be engaging with and embracing a researcher within their midst.

My strength was I had extensive prior experience of challenging positions in developing policies, decision-making and third sector organisations. This enabled the possibility to highlight the shortcomings of the current regulations to improve mental health services through integrated care across the UK. They also led to the conclusion that the front-line workforce and service users' involvement in current policies and directives was minimal. The incorporation of the researcher's background in decision-making and voluntary and community sector organisations has, therefore, been considered to have a positive influence in this study.

I made the conscious decision to refuse to place excessive focus on my background and prior understanding of policymaking and of being the founder of a charitable organisation for mental health. There was consultation with my supervisors on avoiding partialities and it was my commitment to integrating the policymaker and the founder of the charity in mental health that took place over my commitment to be unbiased. Like many others, I was sensitive to embodying some of the facilitators and barriers that are facing integrated care and the improvement of mental health conditions as a researcher in this study. I realised, with some thoughtful apprehension, that I had not really understood what it implied. This might express itself as a trepidation in psychiatric practice, especially at the start of each day, but it diminishes as the day continues.

9.5.1 Insider on the Outside

I sometimes encountered an invisible shroud between the insider and the outsider with both advantageous and disadvantageous results throughout the period of data collecting. There were some benefits to being viewed as an insider and I was a part of certain information that I probably would not have had access to if I had been considered an outsider. However, being an insider also resulted in having the negative feeling of being an intruder at *The Collaborative* breakfast meetings as I had no connection with the research borough, about which the members of *The Collaborative* were discussing the related mental health provisions. When analysing my position in the research, I considered Adler and Adler's (1987) three distinctions between insider and outsider, listed as follows:

1) Researchers who are not involved in the group's core activities are known as peripheral members (outsiders).

2) Active member researchers who become participants in the group's core operations without fully adhering to the members' ideals and goals (outsiders); and

3) Complete researchers who are already members of the group or fully integrated during the study process (insiders).

My engagement in Adler and Adler's categories is difficult to integrate clearly but, essentially, due to my complete disinvolvement with the research borough and *The Collaborative*, my study started with me as a peripheral member researcher.

As I was attending the monthly breakfast meetings of *The Collaborative*, which had the participation of the leadership team, front line staff and the service users, I became familiar with some of the leadership team who would be taking part in the semi-structured interviews. I also presented the findings from the first phase of the study, i.e., the documentary analysis, at one of the breakfast meetings. In addition to the involvement of the gatekeeper at the breakfast meeting, I also requested the leadership team and the members of the four services of *The Collaborative* to express their interest in becoming the participants of the semi-structured interviews and focus groups, respectively. By accepting their culture, it might have been that staff felt that they could open up to me and provide me with the knowledge that an outside person would not be given. At times, I felt as if I was being swallowed up by a mountain of data. I was even approached by service users at the breakfast meetings to be interviewed as part of the study but, due to ethical considerations, I had to decline their request.

During the focus groups, I felt that the front-line staff were keen to open up about the barriers and the challenges with *The Collaborative* as they saw me as a medium to encourage the leadership team to address these problems. The more time I spent with the front-line staff, the more I felt sympathetic towards the employees there and the difficulties they faced in trying to do their duties on a daily basis.

I was cautious enough to record my sentiments in my reflexive diary, and while reviewing my notes on a day away from the data gathering phase, I realised that I had grown engrossed in *The Collaborative* team's life and was beginning to lose focus.

Having conducted all the semi-structured interviews face-to-face, I decided to conduct the focus groups face-to-face and booked two of them. However, due to COVID-19 restrictions, only one focus group was conducted face-to-face as planned and the second focus group had to be postponed. It was stressful obtaining permission to conduct the remainder of the focus groups online using the University of Greenwich approved MS Teams. In addition, I was worried about capturing the data and the feelings of the participants online. The first online focus group was piloted and, after the pilot, I was less nervous about conducting the remainder. Recruiting the participants at this time was also challenging due to staff being ill, self-isolating, the digital divide and the demand for the services from the service users.

My research was challenging and frustrating at times, but it was always inspiring. The thought of completing the data collection during COVID-19 as explained in the limitations and future research section of this chapter had placed additional pressure, and I went through a stressful period. I believe the work achieved here is critical for the future of establishing an integrated mental health system through collective cooperation, as well as for all individuals who suffer from mental health issues. It must be mindful of my privileged insider status as a researcher in this study. In terms of the study's subject matter, it covers an integrated care programme called *The Collaborative* that is facilitating the integrated care process for mental health outcomes in one London borough, and so has the potential to interpret highly sensitive data which has been generated by the study. Burton, Weller and Sharpe (2007) consider the implications of insider status, noting that, while there may appear to be a superficial appearance of peer equality between, in this case, the researcher and the participants, this should not be taken for granted because doing so leads to the embedding of unjustifiable personal assumptions. Insider-contingent bias, which could seek to suppress the voices of the participants or cause the meaning to be corrupted or assigned false degrees of importance, had to be carefully considered during the collection of the research data for my study, and its subsequent analysis. If not addressed, these issues could have far-reaching and unfavourable consequences for future analysis.

Finally, I have considered how my political background and being the founder of a mental health charity could influence the research through my personal values and perspectives. My choice of the research question, methodology, and analysis impose bias on the study because they were chosen based on my opinion of what should be investigating. I feel that any researcher's perspective will inevitably influence their findings, hence bias cannot be avoided. In this regard, I anticipate that Reflexivity section (Chapter 5) will aid in my understanding of how I influenced this research and the positions I adopted that elicited opposing viewpoints. This procedure enabled me to identify and handle all of the issues and problems that I had experienced. It was similar to the importance of self-reflection and supervisor assistance in the development of self-awareness and self-knowledge, which enabled me to conduct this research and guarantee the quality of the results. As a result, the study emphasised the significance of ongoing professional and personal development. Hopefully, this will allow readers to form their own opinions regarding my influence on the research and, as a result, its overall credibility.

9.6 Recommendations

This research demonstrates that further study is needed in the field of integrated mental health care. I hope that this study will pave the way for further research on services within the integration of health and social care in mental health. It is intended that the study's outcomes are mainly applicable to the policy developers, commissioners, local authorities, NHS trusts and VCS organisations who have started and would like to implement integrated care for improving the mental health of their population. In addition, the mental health care practitioners, education and clinical practice and community mental health care services will also benefit from the findings. This research has highlighted the role of VCS organisations in integrated mental health care as the practice of VCS and statutory services working in tandem has become increasingly commonplace.

9.6.1 Recommendations for Practice and Education

VCS and the statutory services should prioritise increasing the amount of time their staff spend with patients and enhancing care. Future services should provide the option of online and telephone support in addition to face-to-face services. This study suggests that stigma is reduced with online and phone services. It is also recommended that supported housing and mental health services are integrated as a practice model as they provide community-based alternatives to inpatient psychiatric treatment, rehabilitation services and forensic step-down services to support people leaving more secure inpatient settings. To address the likelihood of increasing resource constraints in both the VCS and statutory services, they should work together closely to alleviate this, particularly through sharing research findings and gold standard practices when working with primary care and Accident and Emergency services.

It may be beneficial for both VCS and statutory services to design and evaluate training packages to enhance collaborative working. As part of undergraduate and postgraduate training, the contribution of the VCS services, peer support, digital peer support and supported housing should be included. In conjunction with a treatment plan, the approach of the care programme and case management in *The Collaborative* model should be taught in all disciplines. In-service development training, including that for BAME communities, VCS provisions, peer support, digital peer support and supported housing should be provided.

The study demonstrates the benefits of out-of-hours evening support led by non-statutory sector staff and this service should be flexible and expanded to hours when people living with mental health conditions feel most vulnerable, i.e., at night, when they most experience loneliness, feeling isolated and hopelessness. This would replace the use of A and E resources. The current study has raised concerns of voluntary sector staff taking the responsibilities of statutory sector staff. Services and commissioners should work together to see how this can be best addressed. Finally, the findings indicate that more people from BAME communities should be given leadership or similar roles within *The Collaborative* or given comparable provisions.

9.6.2 Recommendations for Policy

The findings from the current study suggest that bringing peer supporters into the hospital wards and GP services would be beneficial. Another recommendation for policymakers would be to increase online peer support as the findings suggest this reduces the perception of stigma. The voluntary, community and social enterprise (VCSE) sector is an important partner for statutory health and social care institutions, and it plays a vital role in enhancing the outcomes of health, wellness and care (NHS Confederation, 2020). Given the findings from this study, it is important to further integrate the VCSE sector into the health and social care system. *The Collaborative* model, which has formed the basis of this thesis, could be a template (with adjustment for local circumstances) for demographically diverse areas similar to the London borough where the study was conducted.

The data from the case study indicate there were significant benefits from integrating mental health provisions and supported housing, and it would be beneficial to implement it out more widely. This is consistent with a report (Hampson, 2021) which suggest a saving of £950 million to the NHS and social care.

9.6.3 Recommendations for Research

Research is needed to explore whether there are financial savings as a result of integrating supported housing and mental health services. Further work is required to investigate the impact of VCS contributions to the integrated mental health care system, and how best all parties can work together.

The study was conducted during the COVID-19 pandemic and the findings indicate the beneficial impact of online and telephone service provision. Further work is required to integrate greater online support services. The findings suggest that online support reduces stigma and is particularly welcomed by BAME communities. These are both areas for further investigation. In general, the findings suggest that *The Collaborative* model is particularly welcomed by BAME communities. Further work should investigate the elements of *The Collaborative* model that are particularly popular so that they can be implemented across different services in ethnically diverse settings. As the service users have not participated in the current study, research should be expanded to include the service users' input to assess both their perceptions of the service and if their requirements were being addressed. Finally, it will be important to measure the outcomes of *The Collaborative* to understand its impact and, in particular, whether it has delivered cost-effective outcomes.

9.7 Conclusion

This chapter is the study's final component, and it emphasises the contribution of the research to current knowledge. This research has offered a useful starting point in reporting *The Collaborative's* efforts to improve mental health care services in one London borough. The strengths and limitations of this research have also been explained, as it was conducted partly during the COVID-19 pandemic. In addition, the implications for mental health practice, education, policy and future research have been outlined. This research's original contribution is that it extends the knowledge of integrated mental health care in an ethnically diverse setting as indicated by the outcomes of a qualitative case study methodology approach. Accordingly, it will serve as a basis to establish strategies, particularly to benefit the overall mental health care service in the UK, through the development of a toolkit that addresses issues related to integrated care. As national and local policies drive transformation in all areas of mental health services in England, this research will inform future policy in integrated care and help to guide future studies about mental health provision in England.

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APPENDICES

Appendix 1 Participant Information Sheet for Interviews / Focus Groups

All participants will be given a copy of this sheet.

University of Greenwich
Southwood Site, Avery Hill Road, Eltham, London SE9 2UG

Research project title**:** Integration of Health and Social Care: A case study of a London Borough

Research Question: How has *The Collaborative* facilitated the integrated care process for mental health outcomes in one London Borough?

Date: 01/03/2019 To 01/09/2019

Introduction

Dear Participant,

My name is Manju Shahul-Hameed. I am a postgraduate research student at the University of Greenwich. From my position as a postgraduate research student, I would like to invite you to take part in a research study. This leaflet is to give you some basic information about my research. Please feel free to ask me for any further details.

Best wishes,
Manju Shahul-Hameed

Invitation

You are being invited to take part in this research project. Before you decide to do so, it is important you understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others, if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

What is this research about?

This research aims to conduct a case study on a London borough to explore *The Collaborative* and understands how it facilitates improved outcomes in mental health. My research will help to explain the views and experiences of the leadership team, professionals and the front-line staff on whether they felt that working within the initiative has contributed to integrated working to help everyone who is experiencing mental health difficulties to recover, stay well, make their own choices and participate on an equal footing in everyday life. Furthermore, it will investigate to what extent the coalition has led to an improved service for service users.

What do you have to do?

Interviews: If I ask you to take part in an interview, you will have time to ask questions, and time to decide if you want to do so or not. You will be given a choice of whether you wish to be interviewed face-to-face or over the telephone. The interviews will be arranged for a time of your choosing.

The face-to-face semi-structured interviews will be recorded using a digital recording device. However, if you do not wish to be recorded, the conversation will be written verbatim by the investigating researcher (me) at the time of the interview. If you choose to partake in a telephone call, it may be recorded using digital media; either by recording loudspeaker conversation or the use of phone call recording software. The interviews will take approximately 30 - 60 minutes.

Focus Groups: If I ask you to take part in the focus group, you will have time to ask questions, and time to decide if you want to do so or not. A suitable date and time will be arranged with you and your workplace manager so that you can be supported to attend the focus group discussion. The focus group discussions will be recorded using a digital recording device. Audio recorded data will be transcribed verbatim before the recordings are destroyed. The focus group meeting will last no longer than 60 mins.

During the interview/discussion, please tell me if you want to stop, or have a break, or opt out of the research. If you do not want to answer any question, just say ‘pass’. You do not have to give me any reason. There are no right or wrong answers. It is your own views on care and development that matter. It becomes impossible to withdraw the data from the research after 31st April 2020.

All participants are expected to uphold their professional boundaries throughout the focus group discussions. Participants should respect each other’s opinions and avoid conflict. Any escalating disruptions will cause the focus group to come to an immediate close. Everything discussed within the focus group must be kept confidential by all participants.

If you decide to take part, you will be given this information sheet and be asked to sign a consent form and I will give you a copy to keep.

What are the possible benefits of taking part?

I hope you will enjoy talking to me. It is hoped that this work could have a beneficial impact on how service users and carers are supported by the NHS and social care. It will be an opportunity for the borough to identify its strengths in integrated care and what is happening in the services. The borough's integrated care can be used as a benchmark which could be transferrable to improve the process, as part of health and social care integration across the London boroughs.

The results will be shared with participants to inform their professional work. The main point of doing the research is to collect and report knowledge that will help service users and staff in the NHS and social care in London boroughs in future.

What if something goes wrong?

If you have any complaints about the project in the first instance, you can contact me or any member of my supervisory team, whose details can be found under 'Contacts for further information'.

Will your taking part in this project be kept confidential?

All the information that we collect about you during the course of the research will be kept strictly confidential. You will not be identifiable in any reports or publications. Your institution will also not be identified or identifiable.

All personally identifiable information will be replaced by a number code to maintain your privacy and confidentiality. With your permission, this information about you will be used to support other research in the future and may be shared anonymously with other researchers.

The interview transcripts will be kept on encrypted computers at the University of Greenwich, with paper transcripts kept locked in filing cabinets at the University of Greenwich research office.

Who has ethically reviewed the project?

This project has been ethically approved by The University of Greenwich Research Ethics Committee (UREC).

Contacts for further information

Dr John Foster, Reader Alcohol Policy and Mental Health Studies, University of Greenwich, email: J.H.Foster@gre.ac.uk, Tel: 0208 331 8757

Dr Panagiotis Pentaris, Senior Lecturer | Fellow HEA, University of Greenwich, email: p.pentaris@gre.ac.uk, Tel: 0208 331 8218

Dr Deborah Watkins, Professional Lead Mental Health, University of Greenwich email: D.Watkins@greenwich.ac.uk, Tel: 0208331 8072

Who are the researchers?

Manju Shahul-Hameed
You can contact me at:
University of Greenwich,
Bronte Building (B117),
Department of Family Care and Mental Health,
Education and Health,
Avery Hill, Avery Hill Road,
Eltham, London SE9 2UG

Email: M.Shahulhameed@greenwich.ac.uk
Tel: 0208 331 8218

Appendix 2 Participant Consent Form

To be completed by the participant. If the participant is under 16, to be completed by the parent/guardian/person acting *in loco parentis*.

- I have read the information sheet about this study ☐
- I have had an opportunity to ask questions and discuss this study ☐
- I have received satisfactory answers to all my questions ☐
- I have received enough information about this study ☐
- I understand that the interview/focus group will be recorded, and a transcript will be produced ☐
- I understand that I am / the participant is free to withdraw from this study:
    - At any time (until such date as this will no longer be possible, which I have been told)
    - Without giving a reason for withdrawing
    - (If I am / the participant is, or intends to become, a student at the University of Greenwich) without affecting my / the participant's future with the University
- I understand that my research data may be used for a further project in anonymous form, but I am able to opt out of this if I so wish, by ticking here. ☐
- I agree to take part in this study. ☐

Signed (participant)	Date
Name in block letters	
Signed (parent / guardian / other) (if under 16)	Date
Name in block letters	
Signature of researcher	Date
This project is supervised by: Dr John Foster, email: J.H.Foster@gre.ac.uk, Tel: 0208 331 8757	

Researcher's contact details (including telephone number and email address):

Manju Shahul-Hameed, Email: M.Shahulhameed@greenwich.ac.uk,

Tel: 0208 331 8218

Appendix 3 Email Invitation for Interviews / Focus Groups

***Invitation to participate in the research project titled*:** Integration of Health and Social Care: A case study of a London Borough

Research Question: How has *The Collaborative* facilitated the integrated care process for mental health outcomes in one London Borough?

Dear (Participant),

I am conducting interviews / focus groups as part of a research project aiming to conduct a case study on a London borough to explore the integrated mental health services in health and social care and understand how they facilitate improved outcomes in mental health. My research will help us to learn about the views and experiences of the leadership team, professionals and front-line staff on whether they feel that working within the initiative has contributed to integrated working to help everyone who is experiencing mental health difficulties to recover, stay well, make their own choices and participate on an equal footing in everyday life. Furthermore, it will investigate to what extent the coalition led to an improved service for service users.

Interviews: As the (Director of Public Health), you are in an ideal position to give us valuable first-hand information on this initiative in your London borough, from your own perspective. The interview will take around 30 - 60 minutes and is very informal. The study is simply trying to capture your thoughts and perspectives on being part of the senior leadership team of *The Collaborative*. Your responses to the questions will be kept confidential. Each interview will be assigned a number code to help ensure that personal identifiers are not revealed during the analysis and write up of the findings.

Focus Groups: The focus group takes around 60 mins and is very informal. Your responses to the questions will be kept confidential. Each focus group will be assigned a number code to help ensure that personal identities are not revealed during the analysis and write up of findings. A suitable date and time will be arranged with you and your workplace manager so that you can be supported to attend the focus group discussion.

There is no compensation for participating in this study. However, your participation will be a valuable addition to my research and findings could lead to greater public understanding and possible policy developments to improve the health and wellbeing of the people in your borough and other London boroughs.

Your participation in this study would be appreciated and is considered a vital component of the overall project. If you are happy to take part in this study, please contact me via email at M.Shahulhameed@greenwich.ac.uk or telephone No. 0208 331 8218 for further information. The questions will be sent to you before the commencement of your interview / focus group.

Thanks and Kind Regards

MANJU SHAHUL-HAMEED

Researcher

This project is supervised by:
Dr. John Foster (University of Greenwich).
Email: J.H.Foster@gre.ac.uk, Tel: 0208 331 8757

Appendix 4 Interview Guide

University of Greenwich, Southwood Site, Avery Hill Road, Eltham, London SE9 2UG

***Research project title*:** Integration of Health and Social Care: A case study of a London Borough

Research Question: How has *The Collaborative* facilitated the integrated care process for mental health outcomes in one London Borough?

(a) Introduction - the first 5 min. (approximately)

The researcher will introduce themselves formally and describe their role for the purpose of this study. The researcher will make it clear that there are no 'right or wrong' answers and the research is interested in the participant's personal views and experience. The researcher will emphasise confidentiality and the anonymity arrangements.

(b) Explain the research and cover the key points on the information sheet and reiterate the aims of the research.

The study aims to answer the overarching question:

How has The Collaborative facilitated improved outcomes in mental health in one London Borough?

By answering the questions through a case study methodology, my research will explore how the integration of mental health services have been (or will be) facilitated by the London borough.

Prior to the commencement of the interview, the researcher will give the participant an opportunity to ask any further questions. They will then ensure that informed written consent has been received and that the information sheet has been given to the participant.

(c) Begin the interview

1.The following topics will be explored.

- Topic 1: The role of (Director of Public Health). 1. What is your role within your organisation? 2. What are your main responsibilities? 3. How is this role situated within *The Collaborative*? 4. How long have you been in that role?

- Topic 2: The delivery of *The Collaborative*:

2. What was the policy and practice on integrated care and mental health provision prior to starting *The Collaborative* and what is the difference today and the progress to achieving the collaborative outcomes, in particular the impact *The Collaborative* has made on the mental health of the population? Can you provide examples of the impact *The Collaborative* has made on the population?

3. What role does your organisation have within *The Collaborative*? What are the specific barriers and facilitators for your organisation in achieving the outcomes developed by *The Collaborative*? Are they different from the barriers and facilitators that the system experiences as a whole? What are the strengths and weaknesses of *The Collaborative*?

4. How has the collaboration and partnership and work of *The Collaborative* impacted the culture and ways of working of staff? Have they adapted to an integrated way of working? Have you developed a new way of working, and what are the strengths and weaknesses of this?

5. How do you feel *The Collaborative* has affected day-to-day practice? Please give examples.

6. What are your metrics for measuring the outcomes? Do you have quality improvement targets? How have you achieved them or what is the plan to achieve them?

7. What do you feel are the main advantages and disadvantages for your organisation having collaborated with your partners?

- Topic 3: Things that could be done differently:

8. What are the lessons learnt? If you were advising the same programme of work to commence elsewhere now, from your own lessons learnt, what would you do differently?

- Topic 4:

9. Please tell us about the partnership model that you have implemented. The type of agreement you have, your governance, and any risk or gain share, pooling of budgets agreements. What are the key benefits of these?

The collaborative outcomes are for people with mental health issues to:

- *Recover and stay well, experiencing improved:*
    - *Quality of life*
    - *Physical and mental health*

- *Make their own choices and achieve personal goals, experiencing increased*
    - *Self-determination and autonomy*
- *Participate on an equal footing in daily life, specifically*
    - *To 'connect' with others e.g. family, friends and neighbours*
    - *To 'give' in the community e.g. community activities, volunteering, peer support*
    - *To 'be included', especially in relation to education, employment, adequate income and stable housing*
    - *To 'participate' on an equal footing with others with reduced stigma and discrimination e.g. access to mainstream services, housing, education and employment.*

d) Conclusion – about 5 minutes:

- Sum up what has been discussed, mention the positive aspects, compliment and thank the participant.
- How did you like talking about the integrated mental health provision with me?
- Is there anything important to you we have not mentioned?
- If you want to follow any issues you have talked about, you can contact us.

Appendix 5 Focus Group Guide

University of Greenwich, Southwood Site, Avery Hill Road, Eltham, London SE9 2UG

***Research project title*:** Integration of Health and Social Care: A case study of a London Borough

Research Question: How has *The Collaborative* facilitated the integrated care process for mental health outcomes in one London Borough?

(a) Introduction - the first 5 min. (approximately)

The researcher will introduce themselves formally and describe their role for the purpose of this study. The researcher will make it clear that there are no 'right or wrong' answers and the research is interested in the participant's personal views and experience. The researcher will emphasise confidentiality and the anonymity arrangements. The participants will be reminded to respect each other's opinions and abide by professional standards and conduct.

(b) Explain the research and cover the key points on the information sheet and reiterate the aims of the research

The study aims to answer the overarching question:

How has *The Collaborative* facilitated improved outcomes in mental health in one London Borough?

By answering the questions through a case study methodology, my research will explore how the ambitions of integration have been (or will be) achieved by the London borough.

The researcher will inform the participants that this study is not a scrutiny of them as individuals/professionals or of their practice, but rather a process that will allow the researcher to answer the aim of the research.

Prior to the commencement of the focus group, the researcher will give the participant an opportunity to ask any further questions. They will then ensure that informed written consent has been received and that the information sheet has been given to the participant.

(c) Begin the focus group
The following topics will be explored.

- Topic 1: The delivery of *The Collaborative*:

1. What steps are taken to ensure that *The Collaborative's* outcomes are achieved, in particular the improvements in the mental health of the population?

Supp: Can you provide examples of how *The Collaborative* has impacted people's mental health?

2. a. What role does your organisation have within *The Collaborative*?

b. What are the specific barriers that prevent your organisation from achieving the outcomes and what are the specific facilitators that help your organisation achieve the collaborative outcomes developed by *The Collaborative*?

c. What are the specific barriers and facilitators for you as an individual staff member to doing your job effectively within *The Collaborative*?

d. What are the positive and less positive elements of *The Collaborative*?

3. How has the collaboration and partnership and work of *The Collaborative* impacted the culture and ways of working of staff? Have you and other staff adapted to an integrated way of working? Have you developed a new way of working and what are the strengths and weaknesses? Can you give an example?

3 a. What tools and techniques have you used to promote sustainable change?
(Ensure it is not just a case of changing the deckchairs but it is about supporting a new way of working and, in particular, the practice of building on what is strong and not what is wrong for people.)

3 b. What main outcomes do you think should be measured to see if integrated working supports a better quality of life for people? What positive changes do you see in people that are an important measure for success? In your opinion, what are the main measures of success?

4. How do you feel *The Collaborative* has affected day-to-day quality of staff practice? Please give examples.

5. What are your metrics for measuring the outcomes people achieve? Do you have quality improvement targets? How have you or what is the plan to achieve them?

- Topic 2: Things that could be done differently:

6. If you were advising the same programme of work to commence elsewhere now, from your own lessons learnt, what would you do differently?

- Topic 3:

7. If you needed something to be changed within the organisation or the partnership to facilitate your own or the team's better working, how would you use the established governance to get a decision or a change made? To what extent does the governance and decision-making of *The Collaborative* work well? What would you change?

The collaborative outcomes are for people with mental health issues to:

- *Recover and stay well, experiencing improved*
    - *Quality of life*
    - *Physical and mental health*
- *Make their own choices and achieve personal goals, experiencing increased*
    - *Self-determination and autonomy*
- *Participate on an equal footing in daily life, specifically*
    - *To 'connect' with others e.g. family, friends and neighbours*
    - *To 'give' in the community e.g. community activities, volunteering, peer support*
    - *To 'be included', especially in relation to education, employment, adequate income and stable housing*
    - *To 'participate' on an equal footing with others with reduced stigma and discrimination e.g. access to mainstream services, housing, education and employment.*

(d) Conclusion – about 5 minutes:

- Anything else you would like to add to what you have said?
- You said earlier…. Could you just run through that to make sure I understand what you meant?
- Finally, is there anything that you think we should have covered, which you would like to talk about?

Appendix 6 Advertisement for Participants

Faculty of Education and Health

Department of Family Care and Mental Health

University of Greenwich

PARTICIPANTS NEEDED FOR

RESEARCH IN

Integration of Health and Social Care

We are looking for volunteers to take part in a study of

How has *The Collaborative* facilitated the integrated care process for mental health outcomes in one London Borough?

As a participant in this study, you would be interviewed individually or part of a focus group

Your participation would involve **ONE** session, a semi-structured interview or as part of a Focus Group lasting approximately **60** minutes.
There is no compensation for participating in this study.

For more information about this study, or to volunteer,
please contact: **Manju Shahul-Hameed**

Department of Family Care and Mental Health

at

Email: **M.ShahulHameed@greenwich.ac.uk**

The study has been reviewed and approved by the Research Ethics Committee, University of Greenwich.

Appendix 7 Permission Letter from the London borough.

NHS
Clinical Commissioning Group
NHS

Email:
Telephone:

University of Greenwich

14 May 2018

FAO University of Greeenwich

Re: Manju Shahul Hameed – PHD Research access

I am writing to confirm that NHS CCG and the London Borough of are in agreement to support Manju Shahul Hameed in her PhD research project to explore the and the and understand how it improves the services for people experiencing mental health issues.

This will access to various reports, data, contact with key stakeholders and attendance at relevant meetings.

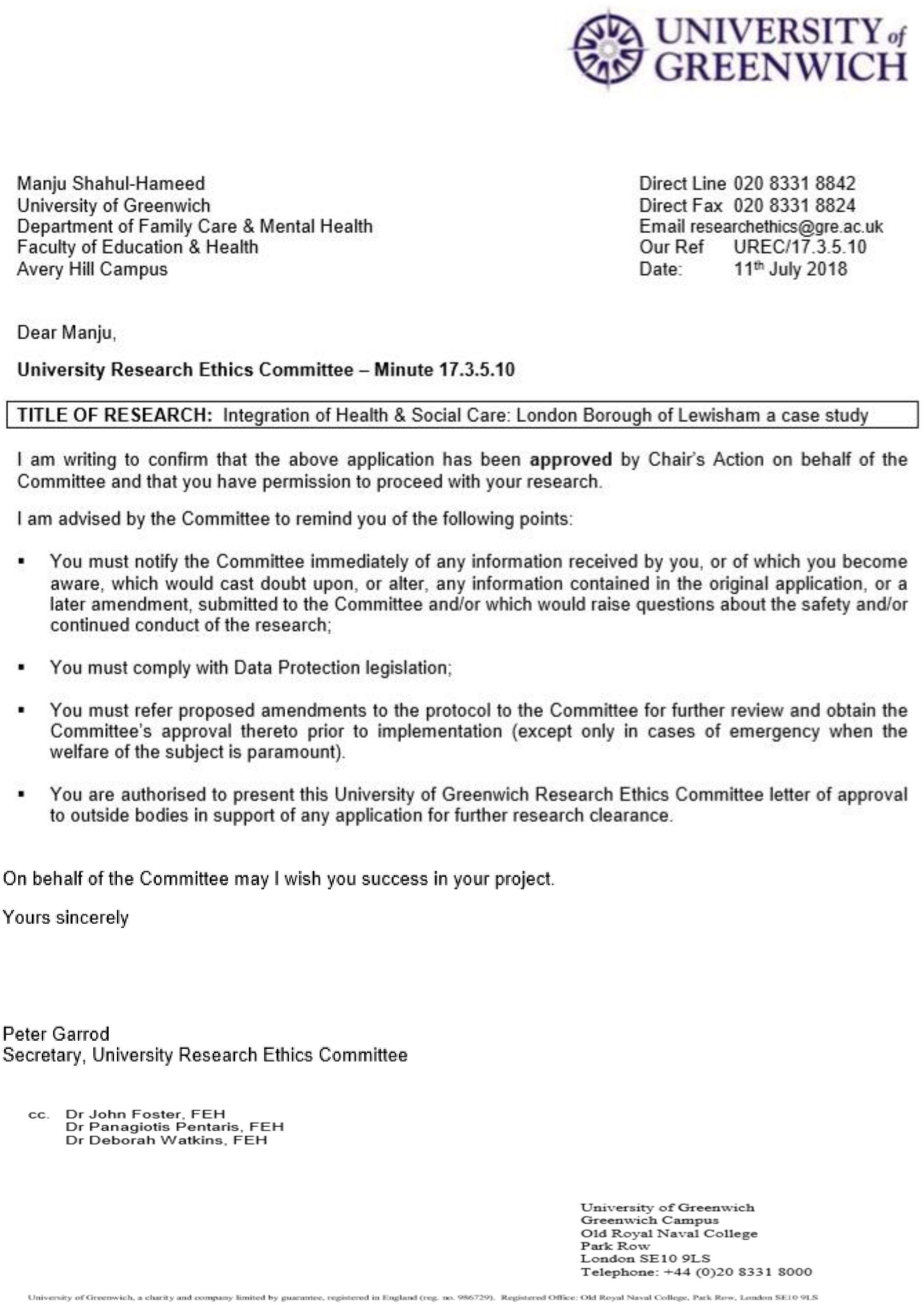
Please contact me should you have any queries.

Regards

Assistant Director –Integrated Commissioning (Mental Health)

CCG Chair Chief Officer

Appendix 8 Ethics Approval from the University of Greenwich



UNIVERSITY of GREENWICH

Manju Shahul-Hameed
University of Greenwich
Department of Family Care & Mental Health
Faculty of Education & Health
Avery Hill Campus

Direct Line 020 8331 8842
Direct Fax 020 8331 8824
Email researchethics@gre.ac.uk
Our Ref UREC/17.3.5.10
Date: 11th July 2018

Dear Manju,

University Research Ethics Committee – Minute 17.3.5.10

TITLE OF RESEARCH: Integration of Health & Social Care: London Borough of Lewisham a case study

I am writing to confirm that the above application has been **approved** by Chair's Action on behalf of the Committee and that you have permission to proceed with your research.

I am advised by the Committee to remind you of the following points:

- You must notify the Committee immediately of any information received by you, or of which you become aware, which would cast doubt upon, or alter, any information contained in the original application, or a later amendment, submitted to the Committee and/or which would raise questions about the safety and/or continued conduct of the research;
- You must comply with Data Protection legislation;
- You must refer proposed amendments to the protocol to the Committee for further review and obtain the Committee's approval thereto prior to implementation (except only in cases of emergency when the welfare of the subject is paramount).
- You are authorised to present this University of Greenwich Research Ethics Committee letter of approval to outside bodies in support of any application for further research clearance.

On behalf of the Committee may I wish you success in your project.

Yours sincerely

Peter Garrod
Secretary, University Research Ethics Committee

cc. Dr John Foster, FEH
Dr Panagiotis Pentaris, FEH
Dr Deborah Watkins, FEH

University of Greenwich
Greenwich Campus
Old Royal Naval College
Park Row
London SE10 9LS
Telephone: +44 (0)20 8331 8000

Appendix 9 Analysis of the collaborative documents using Jupp and Norris analysis framework

Name	What social issues does this policy tackle?	What principles underpin this policy?	What are the policy intentions?	Can you separate the administrative arrangements from their intentions?	Identify the administrative arrangements.	How is power allocated through this policy? To whom? How? Why? At what expense?	What are the policy outcomes (real or desired)? Compare and contrast with policy intentions.
1.Joint working between Council and NHS	Fragmented services, Inequality, requirement for high quality care for ageing population, deliver patient centred care.	Deliver more effective and efficient outcomes for the health, care and well-being of the borough's citizens;	Build total place by joined up working; Improving the health and wellbeing and addressing	Yes	NHS commissioning function moving to GPs; development of three cross-London work streams for governance	PCT exercises the health related functions of the local authority and local	Integration and joined up working; Progress with all the policy intentions.

Name	What social issues does this policy tackle?	What principles underpin this policy?	What are the policy intentions?	Can you separate the administrative arrangements from their intentions?	Identify the administrative arrangements.	How is power allocated through this policy? To whom? How? Why? At what expense?	What are the policy outcomes (real or desired)? Compare and contrast with policy intentions.
		commissioning of health remains focused on the needs of the borough.	health inequalities for people; helping to achieve the cost savings required from the public sector.		arrangements, legal agreements and deliver efficiencies; setting up *The Collaborative*; formation of pooled funds.	authority exercises NHS functions; achieve efficiency savings without impact on outcomes	

Name	**What social issues does this policy tackle?**	**What principles underpin this policy?**	**What are the policy intentions?**	**Can you separate the administrative arrangements from their intentions?**	**Identify the administrative arrangements.**	**How is power allocated through this policy? To whom? How? Why? At what expense?**	**What are the policy outcomes (real or desired)? Compare and contrast with policy intentions.**
						for service users; People with mental health problems, senior managers from both	

Name	What social issues does this policy tackle?	What principles underpin this policy?	What are the policy intentions?	Can you separate the administrative arrangements from their intentions?	Identify the administrative arrangements.	How is power allocated through this policy? To whom? How? Why? At what expense?	What are the policy outcomes (real or desired)? Compare and contrast with policy intentions.
						the Council and NHS.	
2. Establishing a Health and Wellbeing board for the London borough.	Higher risk of poor health and wellbeing and inequalities faced by the residents	High levels of deprivation causing low levels of health and wellbeing;	Restructure the NHS and its regulation, place new public health duties on	Yes	Local Authority to establish a HWB; CCG to participate in the board; undertake Joint Strategic Needs	Government does not intend to take a prescriptive approach to the	Established Healthwatch and Health and Wellbeing board.

Name	What social issues does this policy tackle?	What principles underpin this policy?	What are the policy intentions?	Can you separate the administrative arrangements from their intentions?	Identify the administrative arrangements.	How is power allocated through this policy? To whom? How? Why? At what expense?	What are the policy outcomes (real or desired)? Compare and contrast with policy intentions.
		shaping supportive environments and by supporting communities to take action themselves; partnership that enable to	local authorities, establish a new citizen voice for health and social care (HealthWatch) and new statutory		Assessment (JSNA) and produce a Joint Health and Wellbeing Strategy through the board and to have full regard	role, functions and modus operandi of the rds other than the core functions and membership . Ie. power	

Name	What social issues does this policy tackle?	What principles underpin this policy?	What are the policy intentions?	Can you separate the administrative arrangements from their intentions?	Identify the administrative arrangements.	How is power allocated through this policy? To whom? How? Why? At what expense?	What are the policy outcomes (real or desired)? Compare and contrast with policy intentions.
		achieve improved outcomes and reductions in inequalities; vision for a cooperative borough.	local partnership arrangements called Health and Wellbeing Board.		to both in the planning and commissioning of all their services.	will be with the members; codesigned with NHS and community partners; series of workshops, facilitated	

Name	What social issues does this policy tackle?	What principles underpin this policy?	What are the policy intentions?	Can you separate the administrative arrangements from their intentions?	Identify the administrative arrangements.	How is power allocated through this policy? To whom? How? Why? At what expense?	What are the policy outcomes (real or desired)? Compare and contrast with policy intentions.
						by The King’s Fund, with elected members of all parties, clinical commissioners, community	

Name	What social issues does this policy tackle?	What principles underpin this policy?	What are the policy intentions?	Can you separate the administrative arrangements from their intentions?	Identify the administrative arrangements.	How is power allocated through this policy? To whom? How? Why? At what expense?	What are the policy outcomes (real or desired)? Compare and contrast with policy intentions.
						representatives, and senior officers from the Council, NHS and wider public	

Name	What social issues does this policy tackle?	What principles underpin this policy?	What are the policy intentions?	Can you separate the administrative arrangements from their intentions?	Identify the administrative arrangements.	How is power allocated through this policy? To whom? How? Why? At what expense?	What are the policy outcomes (real or desired)? Compare and contrast with policy intentions.
						services. Local Authority, CCG, members of the board.	
3.Transforming Adult Mental Health Services	Adult mental health and wellbeing and	Freedom, fairness, and	Design local services to best meet the	Yes	Identify mental health problems and intervene	Service transformation work,	Collaborative hub received more

Name	What social issues does this policy tackle?	What principles underpin this policy?	What are the policy intentions?	Can you separate the administrative arrangements from their intentions?	Identify the administrative arrangements.	How is power allocated through this policy? To whom? How? Why? At what expense?	What are the policy outcomes (real or desired)? Compare and contrast with policy intentions.
and Support – The Collaborative	keep people well; and Inequality due to the difficulties in achieving outcomes for people with mental health problems.	responsibility. Strong and cohesive communities provide an environment that fosters improved wellbeing and resilience.	needs of local people; encourage high-quality local commissioning by the use of tools such as payment by results; invest around		early across all age groups; ensure equity of access for all groups, including black communities and every citizen whatever their abilities or	driven by *The Collaborative*, the partnership platform bringing together people who use services and	introductions; Fewer people will develop mental health problems – by starting well, developing well, working well, living well, tackling stigma and

Name	What social issues does this policy tackle?	What principles underpin this policy?	What are the policy intentions?	Can you separate the administrative arrangements from their intentions?	Identify the administrative arrangements.	How is power allocated through this policy? To whom? How? Why? At what expense?	What are the policy outcomes (real or desired)? Compare and contrast with policy intentions.
			£124 million over four years for The Collaborative Hub to receive introductions and provide alternative support in a primary care		disabilities to high-quality, appropriate, comprehensive services; and to build care and support around outcomes that matter to individuals to enable them to	carers, primary care, VCS, secondary care, public health and commissioners from across the whole system in	ageing well; People receiving care and support should have confidence that the services they use are of the highest quality and at least as safe as

Name	What social issues does this policy tackle?	What principles underpin this policy?	What are the policy intentions?	Can you separate the administrative arrangements from their intentions?	Identify the administrative arrangements.	How is power allocated through this policy? To whom? How? Why? At what expense?	What are the policy outcomes (real or desired)? Compare and contrast with policy intentions.
			/ community setting via the Hub.		live the lives they want to live, including those related to good relationships, purpose, education, housing and employment.	relation to working age adults with severe and enduring mental health problems.	any other public service.

Name	**What social issues does this policy tackle?**	**What principles underpin this policy?**	**What are the policy intentions?**	**Can you separate the administrative arrangements from their intentions?**	**Identify the administrative arrangements.**	**How is power allocated through this policy? To whom? How? Why? At what expense?**	**What are the policy outcomes (real or desired)? Compare and contrast with policy intentions.**
4. Integrated Alliance – Adult Mental Health	High levels of need and Morbidity in mental health; recovery and enablement for service users through employment, be in a serious relationship for a long time, take responsibility for	Co-operative model, Section 75 of the 2006 NHS Act, which allows for the delegation of statutory functions from the Council to the NHS; Partners engaged	Establishment of an integrated structure for services comprising commissioning and council services which are	Yes.	NHS and Council to pool commissioning budgets; creation of a multi-agency community rehabilitation service to provide	Performance is overseen by the Mental Health Improvement Programme Board, chaired by the	NHS and Council pool commissioning budgets for Mental Health Rehabilitation Services and then with these pooled funds enter into an Alliance

Name	What social issues does this policy tackle?	What principles underpin this policy?	What are the policy intentions?	Can you separate the administrative arrangements from their intentions?	Identify the administrative arrangements.	How is power allocated through this policy? To whom? How? Why? At what expense?	What are the policy outcomes (real or desired)? Compare and contrast with policy intentions.
	their own living situation and maintain social connections in the mainstream.	in the coproduction, alongside other providers, service users and carers.	aimed to provide: A single, clear identity for local mental health services; Integration of services and teams to be based on		personalised recovery packages of support to every citizen whatever their abilities or disabilities;	Director of Integrated Commissioning; Enable engage and consult Service Users and carers in decision	Agreement with providers in order to support the transformation of health and social care services including commitment to

Name	What social issues does this policy tackle?	What principles underpin this policy?	What are the policy intentions?	Can you separate the administrative arrangements from their intentions?	Identify the administrative arrangements.	How is power allocated through this policy? To whom? How? Why? At what expense?	What are the policy outcomes (real or desired)? Compare and contrast with policy intentions.
			optimal configurations to meet service user needs.			making about services.	black communities and digital maturity.
5. Confederation Proposal	Not being able to access information and advice easily, lack of coordinated	Building on people's existing capabilities, peer support networks,	Establish an alliance of commissioners and providers	Yes.	Develop and expand early, personalised and holistic support; Co-	Improve people's rating of their own	Recover and stay well, experiencing improved

Name	**What social issues does this policy tackle?**	**What principles underpin this policy?**	**What are the policy intentions?**	**Can you separate the administrative arrangements from their intentions?**	**Identify the administrative arrangements.**	**How is power allocated through this policy? To whom? How? Why? At what expense?**	**What are the policy outcomes (real or desired)? Compare and contrast with policy intentions.**
	care, Mental health becoming a priority.	recognising people as assets, facilitating rather than delivering, mutuality and reciprocity.	who will work together to ensure delivery of the functions and achievement of the		ordinate care and drive integration across the system; Manage demand through primary prevention and reducing	mental health; Increase the number of people able to access support in their own homes;	quality of life, physical and mental health; make their own choices and achieve personal goals, to 'give' in the community e.g. community

Name	**What social issues does this policy tackle?**	**What principles underpin this policy?**	**What are the policy intentions?**	**Can you separate the administrative arrangements from their intentions?**	**Identify the administrative arrangements.**	**How is power allocated through this policy? To whom? How? Why? At what expense?**	**What are the policy outcomes (real or desired)? Compare and contrast with policy intentions.**
			outcomes for all of adult mental health.		dependency and crises; Stable employment and housing.	Reduce the number of people becoming dependent on services; and Reduce the physical	activities, volunteering, peer support; To 'participate' on an equal footing with others with reduced stigma and discrimination

Name	**What social issues does this policy tackle?**	**What principles underpin this policy?**	**What are the policy intentions?**	**Can you separate the administrative arrangements from their intentions?**	**Identify the administrative arrangements.**	**How is power allocated through this policy? To whom? How? Why? At what expense?**	**What are the policy outcomes (real or desired)? Compare and contrast with policy intentions.**
						health issues experienced by people with mental health issues.	e.g. access to mainstream services, housing, education and employment

Name	**What social issues does this policy tackle?**	**What principles underpin this policy?**	**What are the policy intentions?**	**Can you separate the administrative arrangements from their intentions?**	**Identify the administrative arrangements.**	**How is power allocated through this policy? To whom? How? Why? At what expense?**	**What are the policy outcomes (real or desired)? Compare and contrast with policy intentions.**
6. Together Integrating and Transition Programme	Fragmentation of services, Lack of collective focus on common outcomes and inequalities.	Improving health and wellbeing and reducing inequalities for the communities.	Better population health outcomes, improved patient experience, deliver person centred care at a lower	Yes	A way of working that involves people who use health and care services, carers and community in equal partnerships; and	System - Shared vision and priorities; Use all assets and experience; Joined up; One budget; Shared values;	Proposal to establish ' Together Transition Programme' to integrate Health and Care in the research borough.

Name	What social issues does this policy tackle?	What principles underpin this policy?	What are the policy intentions?	Can you separate the administrative arrangements from their intentions?	Identify the administrative arrangements.	How is power allocated through this policy? To whom? How? Why? At what expense?	What are the policy outcomes (real or desired)? Compare and contrast with policy intentions.
			cost per person, and improved experience of providing care.		which engages groups of people at the earliest stages of service design, development and evaluation; encouraging	Shared prioirties. Staff - See patients as people and experts.	Some of the key critical success factors identified are Co-production, Culture and workforce development, outcomes,

Name	What social issues does this policy tackle?	What principles underpin this policy?	What are the policy intentions?	Can you separate the administrative arrangements from their intentions?	Identify the administrative arrangements.	How is power allocated through this policy? To whom? How? Why? At what expense?	What are the policy outcomes (real or desired)? Compare and contrast with policy intentions.
					recruitment and retention of highest quality.	People - Health and wellbeing improving for all; Fewer inequalities;	resources, the whole system ownership.
7. Service User not System	Isolation, detained in hospital after being sectioned under the	Co-production, Community-based supported	Cut down on inpatient rehabilitation bed-based	Yes	Setup supported living service	Five organisations are involved in	Reduced the number of people

Name	**What social issues does this policy tackle?**	**What principles underpin this policy?**	**What are the policy intentions?**	**Can you separate the administrative arrangements from their intentions?**	**Identify the administrative arrangements.**	**How is power allocated through this policy? To whom? How? Why? At what expense?**	**What are the policy outcomes (real or desired)? Compare and contrast with policy intentions.**
	Mental Health Act, not being able to live independently.	living accommodation; promote recovery, choice, and community participation and working towards	provision by moving people with long-term mental health issues from institutional settings into specially created independent,		run by voluntary sector provider; Provide 24-hour support from on site staff such as a support worker, psychiatrist, occupational	Integrated Alliance. Aims to reduce the reliance on bed-based residential and institutional provision,	going into residential care by 43 percent. Led to a 79 percent reduction in the number of inpatient placements and

Name	**What social issues does this policy tackle?**	**What principles underpin this policy?**	**What are the policy intentions?**	**Can you separate the administrative arrangements from their intentions?**	**Identify the administrative arrangements.**	**How is power allocated through this policy? To whom? How? Why? At what expense?**	**What are the policy outcomes (real or desired)? Compare and contrast with policy intentions.**
		outcomes identified as important by people using local health and social care services.	community-based supported living accommodation.		therapist and psychologist.	so that people can move to more independent, community-based living.	saved almost £2.5m through offering more recovery focused community alternatives to residential or inpatient provision.

Appendix 10 Participant Information Sheet for Online Focus Group

All participants will be given a copy of this sheet.

University of Greenwich
Southwood Site, Avery Hill Road, Eltham, London SE9 2UG

***Research project title*:** Integration of Health and Social Care: A case study of a London Borough

Research Question: How has *The Collaborative* facilitated the integrated care process for mental health outcomes in one London Borough?

Introduction

Dear Participant,

My name is Manju Shahul-Hameed. I am a postgraduate research student at the University of Greenwich. From my position as a postgraduate research student, I would like to invite you to take part in a research study. This leaflet is to give you some basic information about my research. Please feel free to ask me for any further details.

Best wishes,
Manju Shahul-Hameed

Invitation

You are being invited to take part in this research project because you are a member of a service within *The Collaborative*, the integrated care system. Before you decide to do so, it is important you understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others, if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

What is this research about?

This research aims to conduct a case study on a London borough to explore *The Collaborative* and understand how it facilitates improved outcomes in mental health. My research will help us to learn about the views and experiences of the leadership team, professionals and front-line staff on whether they have felt that working within the initiative has contributed to integrated working to help everyone who is experiencing mental health difficulties to recover, stay well, make their own choices and participate on an equal footing in everyday life. Furthermore, it will investigate to what extent the coalition has led to an improved service for service users.

What do you have to do?

I would like you to participate in a focus group to explore your views on *The Collaborative* and how it has contributed to integrated working and how it has impacted people who are experiencing mental health difficulties. You will have time to ask questions, and time to decide if you want to do so or not. A suitable date and time will be arranged with you and your workplace manager so that you can be supported to attend the focus group discussion. The focus groups will be conducted online using Microsoft Teams; it will be recorded using the University of Greenwich approved Microsoft Teams recording system and will be password protected. During the focus group, at least one of my supervisors will be joining the session as an observer to confirm that there are no online distractions while the focus group is taking place. I also would like to confirm that this study has ethical approval from the University of Greenwich. The recorded data will be transcribed verbatim before the recordings are destroyed. The focus group meeting will last no longer than 60 mins.

During the discussion, please tell me if you want to stop, or have a break, or opt out of the research. If you do not want to answer any question, just say ‘pass’ using the ‘chat’ function or during the discussion using Microsoft Teams. You do not have to give me any reason. There are no right or wrong answers. It is your own views on care and development that matter. It becomes impossible to withdraw the data from the research after 31st August 2021.

All the participants are expected to uphold their professional boundaries throughout the focus group discussions. Participants should respect each other's opinions and avoid conflict. Any escalating disruptions will cause the focus group to come to an immediate close. Everything discussed within the focus group must be kept confidential by all participants.

If you decide to take part, you will be sent this information sheet and be asked to sign a consent form and I will give you a copy to keep. I would be grateful if you could return the completed consent form by email and I will retain your email with the returned consent form as evidence. These expectations will be agreed upon by you once you sign the consent form. We will send you a short end-of-project report once the project is completed.

What are the possible benefits of taking part?

I hope you will enjoy talking to me. It is hoped that this work will have a beneficial impact on how service users and carers are supported by the NHS and social care. It will be an opportunity for the borough to identify its strengths in integrated care and what is actually happening in the services. The borough's integrated care can be used as a benchmark which could be transferrable to improve the process, as part of health and social care integration across the London boroughs.

The results will be shared with the participants to inform their professional work. The main point of doing the research is to collect and report knowledge that will help service users and staff in the NHS and social care in London boroughs in the future.

What if something goes wrong?

If you have any complaints about the project in the first instance you can contact me or any member of my supervisory team, whose details can be found under 'Contacts for further information'.

Will your taking part in this project be kept confidential?

All the information that we collect about you during the course of the research will be kept strictly confidential. You will not be identifiable in any reports or publications. Your institution will also not be identified or identifiable.

All personally identifiable information will be replaced by a coding reference to maintain your privacy and confidentiality. With your permission, this information about you will be used to support other research in the future and may be shared anonymously with other researchers.

The interview transcripts will be kept on encrypted computers at the University of Greenwich, with paper transcripts kept locked in filing cabinets at the University of Greenwich research office.

Who has ethically reviewed the project?

This project has been ethically approved by The *University* of Greenwich
Research *Ethics* Committee (*UREC*).

Contacts for further information

Dr John Foster, Reader Alcohol Policy and Mental Health Studies, University of Greenwich,
email: J.H.Foster@gre.ac.uk, Tel: 0208 331 8757
Dr Panagiotis Pentaris, Senior Lecturer | Fellow HEA, University of Greenwich, email:
p.pentaris@gre.ac.uk, Tel: 0208 331 8218
Dr Gina Finnerty, Senior Lecturer in Midwifery, University of Greenwich
email: G.E.Finnerty@gre.ac.uk, Tel: 0208331 9294

Who are the researchers?

Manju Shahul-Hameed
You can contact me at:
University of Greenwich,
Bronte Building (B117),
Department of Family Care and Mental Health,
Education and Health,
Avery Hill, Avery Hill Road,
Eltham, London SE9 2UG
Email: M.Shahulhameed@greenwich.ac.uk
Tel: 0208 331 8218

Appendix 11 Online Participant Consent Form

To be completed by the participant. If the participant is under 16, to be completed by the parent/guardian/person acting *in loco parentis*.

- I have read the information sheet about this study ☐
- I have had an opportunity to ask questions and discuss this study ☐
- I have received satisfactory answers to all my questions ☐
- I have received enough information about this study ☐
- I understand that the Focus group will be conducted and recorded online using Microsoft Teams and a transcript will be produced ☐
- I understand that I am / the participant is free to withdraw from this study:
    - At any time (until such date as this will no longer be possible, which I have been told)
    - Without giving a reason for withdrawing
    - (If I am / the participant is, or intends to become, a student at the University of Greenwich) without affecting my / the participant's future with the University.
- I understand that my research data may be used for a further project in anonymous form, but I am able to opt out of this if I so wish, by ticking here. ☐
- I agree to take part in this study ☐

Signed (participant)	Date
Name in block letters	
Signed (parent / guardian / other) (if under 16)	Date
Participant Position	
Roles and Responsibilities (participant)	
Name in block letters MANJU SHAHUL-HAMEED	

Signature of researcher	Date
This project is supervised by: DR. JOHN FOSTER	
Researcher’s contact details (including telephone number and email address): Contact Number: 07985603089 Email: M.ShahulHameed@greenwich.ac.uk	

Appendix 12 Email invitation for online Focus Groups

***Invitation to participate in the research project titled*:** Integration of Health and Social Care: A case study of a London Borough

Research Question: How has *The Collaborative* facilitated the integrated care process for mental health outcomes in one London Borough?

Dear (Participant),

I am conducting focus groups as part of a research project aiming to conduct a case study on a London borough to explore the integrated mental health services in health and social care and understand how they facilitate improved outcomes in mental health. My research will help us to learn about the views and experiences of the leadership team, professionals and front-line staff on whether they have felt that working within the initiative contributed to integrated working to help everyone who is experiencing mental health difficulties to recover, stay well, make their own choices and participate on an equal footing in everyday life. Furthermore, it will investigate to what extent the coalition has led to an improved service for service users.

The focus group comprises the front line staff of *The Collaborative* and, as the front line staff, you are in an ideal position to give us valuable first-hand information of this initiative, from your own perspective.

The focus group will last no longer than 60 mins and is very informal. We are simply trying to capture your thoughts and experiences with *The Collaborative*. Your responses to the questions will be kept confidential. Each focus group will be assigned a number code to help ensure that personal identifiers are not revealed during the analysis and the write-up of the findings. A suitable date and time will be arranged with you and your workplace manager so that you can be supported to attend the focus group discussion. Due to the COVID-19 pandemic, the focus groups will be conducted online using Microsoft Teams; it will be recorded using the University of Greenwich approved Microsoft Teams recording system and it will be password protected. During the focus group, two of my supervisors will be joining the session as observers to confirm that there are no online distractions while the meeting is taking place. I also would like to confirm that this study has ethical approval from the University of Greenwich.

If you are staying at home due to the COVID-19 situation, can you ensure that there is privacy at home when you are taking part in the focus group? Can you also ensure that the internet connection is good and the video, speaker and microphone are in proper working condition? In the case of a connection drop off for one of the participants, we will have to cancel the whole focus group and reschedule it. You are welcome to participate in the rescheduled focus group, but if you do not wish to, please let me know and I will go through the process again to find another participant.

All the participants are expected to uphold their professional boundaries throughout the focus group discussions. Participants should respect each other's opinions and avoid conflict. Any escalating disruptions will cause the focus group to come to an immediate close. Everything discussed within the focus group must be kept confidential by all the participants.

If you decide to take part, you will be given this information sheet and be asked to sign a consent form and I will give you a copy to keep. These expectations will be agreed upon by you once you have signed the consent form. I would be grateful if you could return the completed consent form by email. We will send you a short end-of-project report once the project is completed.

There is no compensation for participating in this study. However, your participation will be a valuable addition to my research and the findings could lead to greater public understanding and possible policy development to improve the health and wellbeing of the people in your borough and other London boroughs.

If you are willing to participate in a confidential environment, please suggest a day and time that suits you and I will liaise with the other participants to organise the best available date and time. If you have any questions, please contact me via email at M.Shahulhameed@greenwich.ac.uk.

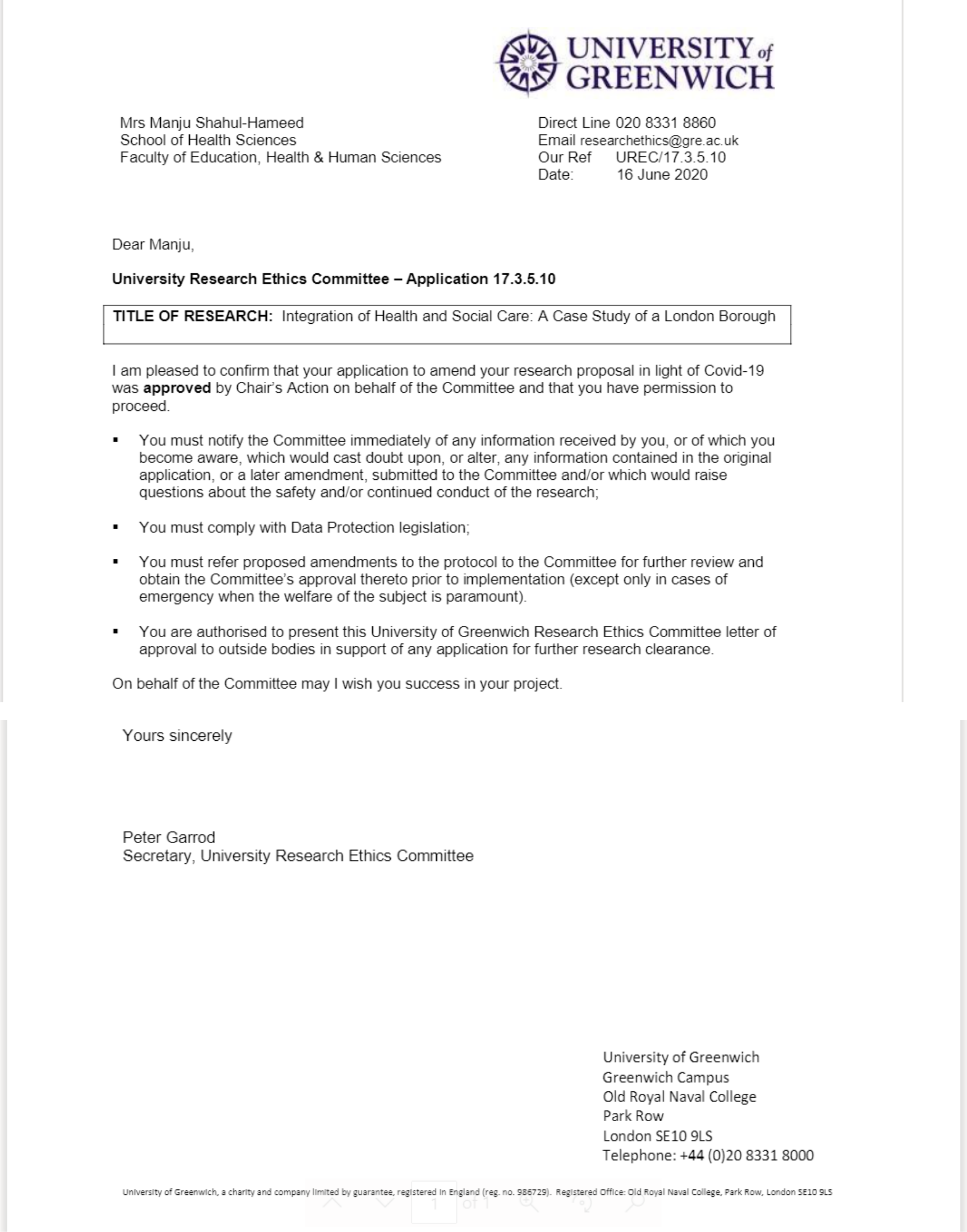
Thanks & Kind Regards

MANJU SHAHUL-HAMEED

Researcher

This project is supervised by: Dr. John Foster (University of Greenwich). Email: J.H.Foster@gre.ac.uk

Appendix 13 Ethics Approval from University of Greenwich on COVID-19 related changes



UNIVERSITY of GREENWICH

Mrs Manju Shahul-Hameed
School of Health Sciences
Faculty of Education, Health & Human Sciences

Direct Line 020 8331 8860
Email researchethics@gre.ac.uk
Our Ref UREC/17.3.5.10
Date: 16 June 2020

Dear Manju,

University Research Ethics Committee – Application 17.3.5.10

TITLE OF RESEARCH: Integration of Health and Social Care: A Case Study of a London Borough

I am pleased to confirm that your application to amend your research proposal in light of Covid-19 was **approved** by Chair's Action on behalf of the Committee and that you have permission to proceed.

- You must notify the Committee immediately of any information received by you, or of which you become aware, which would cast doubt upon, or alter, any information contained in the original application, or a later amendment, submitted to the Committee and/or which would raise questions about the safety and/or continued conduct of the research;
- You must comply with Data Protection legislation;
- You must refer proposed amendments to the protocol to the Committee for further review and obtain the Committee's approval thereto prior to implementation (except only in cases of emergency when the welfare of the subject is paramount).
- You are authorised to present this University of Greenwich Research Ethics Committee letter of approval to outside bodies in support of any application for further research clearance.

On behalf of the Committee may I wish you success in your project.

Yours sincerely

Peter Garrod
Secretary, University Research Ethics Committee

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