



**THE UNIVERSITY  
OF BIRMINGHAM**

## **Protocol**

### **Long title:**

**Investigating the contribution of the voluntary sector to mental health crisis care in England**

### **Short title:**

**The voluntary sector role in mental health crisis care in England**

**NIHR HS & DR Reference: 15/70/73**

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**University of Birmingham reference: RG16-153**

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## SIGNATURE PAGE

The undersigned confirm that the following protocol has been agreed and accepted and that the Chief Investigator agrees to conduct the study in compliance with the approved protocol and will adhere to the principles outlined in the Declaration of Helsinki, the Sponsor's SOPs, and other regulatory requirement.

I agree to ensure that the confidential information contained in this document will not be used for any other purpose other than the evaluation or conduct of the investigation without the prior written consent of the Sponsor

I also confirm that I will make the findings of the study publically available through publication or other dissemination tools without any unnecessary delay and that an honest accurate and transparent account of the study will be given; and that any discrepancies from the study as planned in this protocol will be explained.



Signature:

Date: 15/01/18

Name: Dr Karen Newbigging

Position: Chief Investigator

### Sponsor statement:

Where the University of Birmingham takes on the sponsor role for protocol development oversight, the signing of the IRAS form by the sponsor will serve as confirmation of approval of this protocol.

## KEY STUDY CONTACTS

Chief Investigator	<p>Dr Karen Newbigging  Senior Lecturer in Health Policy and Management  Health Services Management Centre  School of Social Policy  The University of Birmingham  Park House  40 Edgbaston Park Road  Birmingham B15 2RT</p> <p>Mob:07974-929367</p> <p><a href="mailto:k.v.newbigging@bham.ac.uk">k.v.newbigging@bham.ac.uk</a></p>
Study Co-ordinator	Dr Karen Newbigging (as above)
Sponsor	<p>Dr Sean Jennings  Head of Research Governance  University of Birmingham</p> <p>0121 415 8011</p> <p><a href="mailto:researchgovernance@contacts.bham.ac.uk">researchgovernance@contacts.bham.ac.uk</a></p>
Joint-sponsor(s)/co-sponsor(s)	N/A
Funder(s)	NIHR HS &DR
Key Protocol Contributors	<p>Professor John Mohan  Professor of Social Policy and Director of the Third Sector Research Centre  School of Social Policy, TSRC  Park House  University of Birmingham  Edgbaston  Birmingham  B15 2RT</p> <p><a href="mailto:j.mohan@bham.ac.uk">j.mohan@bham.ac.uk</a></p> <p>0121 414 5405</p> <p>Dr James Rees  <a href="mailto:james.rees@open.ac.uk">james.rees@open.ac.uk</a></p>
Committees	<p>Study Steering Group  Chair: Jacqui Dyer  c/o Health Services Management Centre  School of Social Policy  The University of Birmingham  Park House  40 Edgbaston Park Road  Birmingham B15 2RT</p>

	Mob: 0701823038
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## STUDY SUMMARY

Study Title	Investigating the contribution of the voluntary sector to mental health crisis care in England
Internal ref. no. (or short title)	Contribution of the voluntary sector to mental health crisis care in England
Study Design	Mixed methods: case study design
Study Participants	Third sector organisations (managers and volunteers) Department of Health policymakers NHDS and LA staff (commissioners and practitioners) Third sector service users and carers NHS service users and carers
Planned Size of Sample (if applicable)	Approx 300 for survey Approx. 230 participants in interviews and focus groups
Follow up duration (if applicable)	N/A
Planned Study Period	November 2016 - Jan 2019
Research Question/Aim(s)	What is the contribution of the voluntary sector to crisis care pathways in mental health?

## FUNDING AND SUPPORT IN KIND

<b>FUNDER(S)</b> (Names and contact details of ALL organisations providing funding and/or support in kind for this study)	<b>FINANCIAL AND NON FINANCIALSUPPORT GIVEN</b>
NIHR	Financial support
West Midlands CRN	Non-financial support
Suresearch	Non-financial support

## **ROLES AND RESPONSIBILITIES OF STUDY MANAGEMENT COMMITTEES/GROUPS & INDIVIDUALS**

### **Study Steering Group (SSG)**

The role of the SSG is to provide overall supervision for a project on behalf of the Project Sponsor and Project Funder and to ensure that the project is conducted to the rigorous standards set out in the Department of Health's Research Governance Framework for Health and Social Care and the Guidelines for Good Clinical Practice. The day-to-day management of the project is the responsibility of the Chief Investigator. The specific aims of the SSG are to:

1. Provide advice on all appropriate aspects of the project
2. Concentrate on progress of the study, adherence to the protocol, patient safety (where appropriate) and the consideration of new information of relevance to the research question
3. Ensure the rights, safety and well-being of the participants are the most important considerations and should prevail over the interests of science and society
4. Ensure appropriate ethical and other approvals are obtained in line with the project plan
5. Agree proposals for substantial protocol amendments and provide advice to the sponsor and funder regarding approvals of such amendments
6. Ensure clarity in the direction and focus of the project, ensuring that it addresses the key stated objectives.
7. To cascade information about the project to other organisations and associated networks.

The SSG has to have a minimum of 75% majority of independent members. The minimum quoracy for a meeting to conduct business is 67% of appointed members. Only appointed members will be entitled to vote and the Chair will have a casting vote. The Chair and members to sign and maintain a log of potential conflicts and/or interests

### **Service User Reference Group**

The purpose of the user-led reference group is to act as a critical friend to the research study, to inform the development of the research tools and the lines of inquiry and comment on emergent findings. In particular, it will discuss:

- Risks to service users involved and ethical matters
- Types of voluntary organisations contacted
- All tools involved, including interviews, focus groups and surveys – for stakeholders and service user participants.
- Practical decisions, e.g. locations chosen for study, how to recruit service user participants and how soon after crisis to interview them
- Ongoing interpretation of results as they emerge
- Ideas concerning limitations and future work

This group consists of 8 people with representation from people with personal experience of a mental health crisis and carers and the Chair is a member of the SSG.

## BACKGROUND AND RATIONALE

Theoretical conceptualizations focus on a crisis as a 'turning point', with both risks and constructive potential for change and personal transformation for people experiencing a mental health crisis (Hobbs, 1984). Definitions of crisis, however, cover a broad range of needs and can reflect an individual's capacity to cope, available resources that can be mobilised and the effectiveness of on-going care and support (Ryan et al., 2001). The definitions of crisis currently in use distinguish a pragmatic service-oriented approach (i.e. a person coming to the attention of crisis services because of a relapse of an existing mental health condition); self-definitions of crisis (i.e. the person defines their own experience and recovery); a risk-focused definition (i.e. the person is at risk of harming themselves or others) and negotiated definitions (i.e. negotiated collaboratively between service users, carers and professionals) (Paton et al. (2016:1). This study begins with the conception of a crisis as a 'turning point', such that a mental health crisis is personally disruptive but can provide opportunities to strengthen personal and social resources and to anticipate and manage mental health, leading to improvements in health and wellbeing. This definition is broad enough to encompass user-defined conceptions of crisis and service-oriented definitions and to reflect the diverse range of support to prevent, respond, manage and recover from a mental health crisis.

### ***Effective crisis support and the role of the voluntary sector***

If not managed well, the experience of a mental health crisis can have a long lasting and negative impact not only for the individual concerned but also their family, and may influence their capacity for self-management and willingness to seek help in the future. Consequently, the provision of effective mental health crisis support has been a cause for concern since the replacement of institutional care with community based services. In an English context, the Care Quality Commission (CQC) has recently identified that these concerns still prevail and mental health crisis care provision remains both inconsistent and inadequate (CQC, 2015a). Resonating with the findings from a survey of service user and families' experiences of crisis care (McPin, 2015), the CQC have concluded that many people in crisis are unable to access the help they need, when they need it and are dissatisfied with the help when they receive it (CQC, 2015a).

Whilst statutory services form a key strand of the mental health crisis response across these domains, it is evident that there needs to be a broad range of initiatives that promote resilience, wellbeing, empowerment and care for people in crisis, including those provided by the voluntary sector (i.e. not for profit organisations) (Mind, 2011; HM Government, 2014; Home Office, 2015). The voluntary sector (VS), also commonly described as the third sector, provides a broad range of services across the four domains identified by the Crisis Care Concordat (HM Government, 2014):

- Access to support before a crisis through provision of information, preventive activities and supporting self-directed care
- Urgent and emergency access to crisis care
- Quality of care during a crisis including alternatives to inpatient admission
- Recovery and relapse prevention enabling people to stay well

The complexity of crises means that there is not a single crisis care pathway and the configuration of crisis care pathways varies depending on when and how someone first presents with a crisis (HM Government, 2014). The configuration of these pathways is better understood where the first approach is to statutory services (e.g. GP, 111, NHS crisis services or A & E), although it is clear that these need to be a focus for improvement (CQC, 2015a). There will also be a group of service users who are reluctant to use statutory services as their first port of call, and may turn to the VS in a crisis. It is therefore, important to understand this pathway and to identify how collaboration between VS and statutory services could facilitate access to appropriate support.

The focus for our study is to understand how the crisis care pathways are configured and where VS services fit into this, as there is a knowledge gap around the broader VS offer, beyond crisis housing<sup>1</sup>. Our contribution will be to clarify this, which will be valuable in a context of the current mental health transformation agenda that promotes the better use of public services and closer collaboration with the VS<sup>2</sup>.

Building on our expertise of researching the VS, we conceptualise this sector as a space of organisational activity located between the state, market and private familial spheres. It comprises a diversity of organisational types including charities, social enterprises, co-operatives and faith, community and grassroots groups. (Rees and Mullins, 2016). The VS has played a key role in identifying the needs of people in a mental health crisis, responding to policy initiatives to improve mental health crisis care and addressing the gaps in statutory provision (Mind, 2011). VS sector crisis support ranges from help-lines to crisis houses, offering an alternative, and potentially complementary, adjunct to statutory crisis provision through providing a non-medical response that focuses on the person's situation and seeks to empower them in dealing with their crisis. This is underpinned by a sector ethos that typically values accessibility, self-organisation, service user-defined outcomes, informality and relational-based approaches (Froggett, 2015). The sector has provided leadership in terms of developing recovery-oriented approaches and peer support (Mind 2013; Centre for Mental Health, 2013); developed innovative models of care (for example in the provision of alternative places of safety (Home Office, 2015)) and played a key role in meeting the needs of specific communities, notably for people from Black, Asian and minority ethnic (BAME) communities, who are known to avoid using statutory mental health services (CQC, 2012). Furthermore, there is a growing body of evidence that not only do service users prefer residential crisis houses, mainly provided by voluntary sector organisations (VSOs, to inpatient psychiatric care, they are less stigmatizing and coercive, thus, proving a viable alternative for people not needing close supervision and observation (Fenton et al., 2002; Howard et al., 2008; Johnson et al., 2009; Sweeney et al., 2014). In addition, there is some evidence that they may be more cost-effective (Fenton et al., 2002; Howard et al., 2010) and, in building on informal peer support, extend the networks and repertoire in the event of future difficulties (Sweeney et al., 2014).

## **Evidence base for the voluntary sector contribution to mental health crisis care**

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<sup>1</sup> See for example description of the London Mental Health Crisis Path. Available at: <http://www.londonhp.nhs.uk/wp-content/uploads/2012/05/London-Mental-Health-Crisis-Pathway.pdf> [accessed 300616].

<sup>2</sup> See for example the use of social prescribing.



An initial literature review for this study identified that the research endeavour has largely focused on statutory provision, notably in relation to Crisis Resolution Teams (Onyett et al. 2006; Rhodes, and Giles, 2014; Wheeler et al. 2015) and that there are key gaps in the evidence base for effective mental health crisis care (Paton et al., 2016). Studies that have considered the role of VS services have tended to focus on crisis houses, comparing them with standard psychiatric in-patient care and often for women (Howard et al., 2008; 2010). It is clear from this that there is a significant knowledge gap because the voluntary sector contribution is much broader than the provision of crisis houses and also includes services that may not be badged as mental health projects but are nonetheless providing crisis support, as is the case with VSOs supporting homeless people, for example (Ryan et al., 2001). Moreover, while large national charities tend to have a high profile in this field, less is known about the range of services provided by smaller organisations, particularly those operating informally, or about how the division of labour between providers operates on the ground.

In addition, variations in the distribution of voluntary sector services, and the extent to which their contributions are integrated into local crisis care pathways, are not clear, although the importance of different agencies working together to ensure there is an effective crisis care pathway is repeatedly emphasised in policy (Department of Health, 1999; HM Government, 2014). From previous literature on the voluntary sector, there are problems characterised as “voluntary failure” (Salamon, 1987): essentially an inability to match provision with need. Previous research by team members has identified voluntary resources are not necessarily distributed in relation to patterns of social need but in relation to the distribution of causes in which donors and supporters are interested, or with which they have a personal connection (Mohan and Breeze, 2016). This literature suggests that the distribution of voluntary organisations and volunteers will be uneven, raising policy concerns that those experiencing crises may receive more or less support, depending on where they live: something of a “postcode lottery”. It is therefore timely to investigate the voluntary sector contribution and how it might be used to best effect to ensure high quality crisis care.

### **Theoretical background**

This study is foundational in terms of developing the theoretical basis for the role of the voluntary sector in responding to mental health crises. Whilst we start with insights from the disciplines of social science and organisational studies, there is scope to develop more relevant and robust theories and concepts in this area. There are two theoretical lenses that are particularly pertinent and which we will draw on in developing the analytic framework. The first is the conception of crisis as a turning point in creating opportunities for the development of personal and social capacity (Hobbs, 1984); and the second concerns the role and nature of the voluntary sector when it is closely intertwined with and involved in the delivery of the wider 'system' of public services.

An important aspect of the conceptualisation of crisis is the temporal dimension, as articulated by the conception of the crisis care pathway by the Crisis Care Concordat (CCC). We are framing the turning point elicited in a mental health crisis in relation to the work of Amartya Sen (1993), which places a strong emphasis on human agency (i.e. self-determination) and adopts a critical stance towards social welfare programmes that target wellbeing but ignore or impair agency. This is coupled with a concern with context and a focus on what people are able to do as a result of the social and material resources available

to them (Rowe et al., 2011), thus, foregrounding agency in recasting our understanding of how mental health systems, with VSOs as constitutive elements, can enhance or limit personal capacity.

The other theoretical foundation relates to conceptualising the contribution of the voluntary sector, which potentially provides a space of distinctive practices, relations and ethos, reflecting the marked involvement of current and former service users in the voluntary sector, thus reducing the power differential between expert/user. It is postulated that this relational aspect provides a comparative advantage in terms of building personal capacity (Billis, and Glennerster, 1998; Macmillan, 2013) and, thus, voluntary sector organisations, and their distinctive ways of working, offer a specialist 'niche' within a wider ecosystem of mental health crisis support. In order to operationalise this within our study, our inclusion criteria for service user participants will require that they have experience of using voluntary sector services and statutory provision to enable us to understand how the different services are working together and how. For example, an interesting question is whether VSOs are providing a distinctive contribution or serving to fast track people in crisis in to NHS provision.

The voluntary sector has been conceptualised as a 'third' space of organisations between the state and market, comprising charities, social enterprises, and community groups, which exhibit potentially unique attributes such as being driven by social mission, closeness to and expertise on communities, and beneficiary involvement in governance (Carmel and Harlock, 2008). Where VSOs work most closely in 'partnership' with the public sector, the relationship has been theorised as a collaborative one arising from the inherent limitations of the two sectors in providing collective services (Salamon, 1987) – suggesting there is scope for synergy. The voluntary sector is particularly well positioned to support excluded groups because of 'stakeholder ambiguity' (Billis and Glennerster, 1998), which implies relatively flat hierarchies and blurring between staff, volunteer and 'user' roles in the organization, aligned with cultures of non-judgementalism, nurture/care, and 'relational skill'. These characteristics mean that the VS may be particularly well placed to respond to mental health crises, and offer an alternative approach to statutory provision. However some theorists have warned that current commissioning and contracting/system arrangements are undermining the distinctive characteristics of the voluntary sector (Carmel and Harlock, 2008); although it is also recognised that commissioners have a difficult and conflicted role, for instance in 'shaping' and managing markets (Miller and Rees, 2014). Some have gone further, criticising the notion of two independent sectors in such circumstances, and characterising the relationship as one of 'mutual dependence' (Lipsky and Smith, 1989). The implication is that such services are mutually constitutive and there are barriers to exit of either sector. The challenge for public service managers and commissioners is in fostering and managing such – potentially fragile – systems and this project will be guided by this recognition of the institutional and social construction of such complex systems. Drawing on this, this study will therefore explore what the contribution of the voluntary sector is to mental health crisis care, and how the voluntary and statutory sectors work together to respond to such crises: in synergy, mutual dependence, in competition, collaboration or conflict.

Our starting point for a theoretical framework for understanding the collaboration between VSOs and statutory NHS and social care services draws on the work of Morrissey et al. (1994) in the US on service system change and the collaboration and integration between

different types of services to provide a coherent response to the needs of people experiencing a severe mental illness. This body of work identifies collaboration as taking place at two levels – at the service system level and the individual client level. This underpins our approach to the research design in seeking to understand both how different elements of the crisis service system are working together and how this is experienced at an individual service user level.

There is rarely a clear definition of the term collaboration and in this context we are drawing on the conceptualization of collaboration by Gray (1989) of collaboration as “*a mechanism by which a new negotiated order emerges among a set of stakeholders*”. Thus our working hypothesis is that effective collaboration between VSOs and the public sector will provide a more effective and efficient response to people experiencing a mental health crisis and we aim to elucidate the facilitators and barriers to such collaborative relationships. Gadjia (2004) provides a continuum of integration from cooperation to coadunation, with collaboration defined as integrated strategies and collective purpose. Our data collection within the local sites will enable us to assess the degree of collaboration, using a system questionnaire developed by Morrissey et al. (1994) to operationalise this definition for our research.

### **Evidence of why the research is needed now**

Current mental health policy emphasises that people with a mental illness have the right to the same high quality of care as people with physical health problems (NHS England, 2014). This includes access to appropriate care and support in a crisis and the CQC, and others, have highlighted that this continues to be problematic and is especially so for particular groups, including children and young people (CQC, 2015). Work commissioned by NHS England from the National Collaborating Centre (National Collaborating Centre for Mental Health (2015) and the Mental Health Crisis Care Concordat, with its focus on securing local agreements are central to improving the crisis care pathway. The Crisis Care Concordat, introduced in 2014, has stimulated the development of a range of voluntary sector initiatives, notably crisis houses that provide an alternative to inpatient care and appreciated as such by service users (Howard et al., 2010; Sweeney et al., 2014). However, the need for better working between different organisations, including the voluntary sector, to improve the system response to people experiencing a mental health crisis is evident. Indeed, the interim evaluation of the Crisis Care Concordat found that the quality of local partnerships varied and was often grounded in a lack of appreciation of the roles of different organisations (McPin, 2015). Furthermore the recent Commission to review the provision of acute inpatient psychiatric care for adults has reinforced the importance of viewing the mental health system as a whole and ensuring synergy between all of its component parts to provide a timely response (Royal College of Psychiatrists, 2016).

This research is also needed because of the increasing rates of uses of the Mental Health Act, which are now at a record high (CQC, 2015b). This rise is a worrying trend and more so because of the evidence that people may not be routinely informed of their rights (CQC, 2015b); that cultures of containment rather than care are to be found (CQC, 2012) and access to independent advocacy problematic, particularly for marginalised groups (Newbigging et al., 2007; 2012; 2014; 2015). This may prevent people from accessing services at a time when the suicide rate for specific groups is showing a sharp increase (The National Confidential Inquiry, 2015). In addition, conditions of austerity also increase the likelihood of a mental health crisis for the whole population and place people with existing

mental health issues at greater risk of experiencing episodes of crisis (The National Confidential Inquiry, 2015) disadvantage people at risk further. The current economic situation of the NHS and Local Authorities also underlines the obligation on public services to use their resources to best effect.

It is, therefore, extremely timely to address this knowledge gap to understand the range and nature of the contribution of the VS, to appreciate its role in mental health crisis care, and to identify the policy and practice implications. Consultation with the National Clinical Director for Mental Health, the Crisis Care Concordat lead and a sample of Clinical Commissioning Group (CCG) mental health leads, support the need to strengthen the evidence base relating to the voluntary sector role in crisis care and the sector gateway into statutory health and social care services. Finally, this research is also well-timed given the government's focus on determining the future role of voluntary sector involvement in health and social care (NHS England, 2015).

The findings will inform the future commissioning of the VS and ensure that the contribution of voluntary organisations is used to best effect. It provides a platform for further research to investigate the effectiveness of different models and this has the potential to lead to reduction in costs, through the provision of services that are less intensive, more acceptable and less costly, for example access to peer support as opposed to more costly professional services. The research will enable the identification of innovative and promising approaches and, therefore, contribute to the redesign of services to support the transformation agenda in mental health in order to enable round the clock access.

## **RESEARCH AIMS AND OBJECTIVES**

The primary aim of this research is to identify the contribution of the voluntary sector to crisis care pathways in mental health and to make policy and practice recommendations to strengthen the crisis care response in mental health. It will provide a platform for subsequent research to evaluate the effectiveness of different voluntary sector models. To this end the project has five key research objectives:

1. To identify the different types of VS support being commissioned and provided to respond to the care needs of people experiencing a mental health crisis.
2. To develop a taxonomy of the different organisational types (e.g. social enterprise, charity, Community Interest Company etc.), and forms (e.g. national, local etc.) of VS support available, service models including characterisation of their relationships with statutory provision, and populations served.
3. To investigate the experience of different stakeholders and outcomes for service users of the contribution of different types of VS support to the crisis care system.
4. To identify the factors and processes that facilitate the successful contribution of the voluntary sector to effective crisis care pathways.
5. To identify the policy and practice recommendations to strengthen the mental health crisis care response. This will include the implications for commissioning and the interface with mental health services provided by the NHS and local government so that the contribution of the voluntary and statutory sectors are integrated to ensure a rapid and appropriate response.

The scope of the study is mental health crisis care in England. Clinical outcomes and comparisons with different types of service provision are beyond the scope of this study, which will provide a platform for further research of this nature.

## **STUDY DESIGN AND METHODS OF DATA COLLECTION AND ANALYSIS**

The study is designed to work from national level perspectives and data on the contribution of the VS, through to the experience of individuals of local VS services. The balance of qualitative and quantitative material varies at these different levels of investigation with the quantitative material being relied on for what Sayer (1984; 2000) characterises as an “extensive” approach, describing broad patterns of a phenomenon, while the qualitative material is drawn upon for “intensive” investigations of outcomes and processes. Case studies are particularly useful for enabling a real-time exploration of phenomena that are complex and dynamic (Yin, 2011) and a case study design, therefore, involves an intensive examination of the voluntary sector contribution and has the potential to contribute to theoretical insights that can then be applied in other contexts. The study design ensures that the qualitative work is always capable of being related to the wider picture through locating the qualitative data in a typology of voluntary sector organisations derived from the quantitative data.

The research design involves the use of multiple methods to provide a comprehensive and detailed analysis of the contribution of the VS to mental health crisis care. An overview of the research design is attached at Appendix 1. To address the research objectives, the study is organised around four distinct but inter-connecting work packages. The quantitative and qualitative packages therefore complement one another. Work package (WP) 1, will provide a detailed description of the kinds of organisations involved in mental health care delivery, of which ones are involved in crisis care, and of the details of the types of services they provide. While we will generate a macro-level picture with the accounts data and procurement data from CCGs, this will not necessarily provide exhaustive local detail. Hence, WPs 2 - 4 are designed to flesh out the detail of VS provision in more depth, with greater emphases on qualitative methods and a focus on process and on individual experience.

### **Work Package 1: National scoping exercise**

Work package one will address Objective 1 to identify the range of support VSOs are providing to people experiencing a mental health crisis. It involves building a national picture of the contribution of the range of voluntary sector providers of crisis care. This will have two elements: (a) a national survey of VSOs to identify the type of crisis support being commissioned and provided and to whom; the type of organisation providing the support and main methods of working. (b) a selected sample of interviews with national stakeholders (Department of Health, NHS England, professional organisations) and national VSOs to provide further detail on the different forms of VSOs and the type of crisis support they provide and how this contributes to the crisis care pathway.

The services available in communities in non-institutional settings for people experiencing mental health crises are likely to be diverse and an exhaustive national mapping is beyond the scope of this project. Instead the aim is to illustrate, through regional and local case studies, the broad range of services that are available. Such services could be provided through specialist mental health VSOs, but an organisation primarily concerned with

homelessness, or with a client group such as ex-service personnel, could be serving individuals with mental health crises, and so identifying those organisations whose primary purpose is mental health service provision might well miss other entities. Furthermore, while many VSOs are visible by virtue of their position on the “radar” of regulators such as the Charity Commission, many small-scale less formalised groups are not, so our local case studies will be designed to identify cases where such groups are involved. WP 1 will enable us to identify the precise nature of these services. From a review of the Crisis Care Concordat Action Plans, the types of services that are likely to be included are:

- Mental health helplines, mental wellbeing hubs and activities with seldom heard groups to increase mental health awareness and providing information, signposting and early intervention in a crisis; in addition, information and resources to stay well and prevent a mental health crisis, with links to primary care through social prescribing (i.e. access to support before a crisis).
- Crisis houses, providing immediate respite and an alternative to inpatient care and/or alternatives to places of safety, and provision of crisis advocacy to facilitate access to appropriate support (i.e. urgent and emergency access to crisis care).
- A range of advocacy and peer support to ensure that an individual's voice is heard, their rights safeguarded and the best quality of care is provided (i.e. quality of care during inpatient admission).
- Peer support, recovery-oriented courses and workshops programmes (i.e. recovery and relapse prevention).

The VS in the UK contains over 200,000 registered and regulated non-profit organisations taking various legal forms. Searching these for entities providing crisis care is a formidable task but the sector is served by many umbrella bodies: specialist organisations, providing support to particular subsets of the VS population. In this field, the Crisis Care Concordat (CCC) and main VSOs will have good knowledge of the principal actors, but it is a well-known challenge of VS research that what may appear to be authoritative listings of organisations do not always include every organisation in a particular field, and that information is often out of date (Mohan, 2011; 2012). This information will be augmented by using two further sources of data on potential candidate organisations, building on the work of the Third Sector Resource Centre (TSRC) to ensure that our sampling frame for survey and case study research is as robust as it can be. These are:

- **The Register of Charities**

TSRC, led by Mohan, has developed very substantial databases on c. 160,000 registered charities in England and Wales, covering their finances and activities for a 20 year period and classified organisations according to subsets of the ICNPO (International Classification of Nonprofit Organisations) classification (Salamon and Anheier, 1996). There are c. 1400 charities operating in the mental health field (ICNPO 3300) as their primary purpose, so using this information we will generate listings of charities involved in the delivery of mental health services and cross-reference it against information such as that provided by the Crisis Care Concordat and key experts in their field. This data will be used to develop and refine a listing of organisations active in the mental health field.

- **Procurement data**

Recent government decisions require CCGs to make publicly available information about transactions with external parties of a value in excess of £25,000. Mohan is leading an ESRC funded project which is developing the use of CCG (and other public sector) data for research purposes. The information shows which charities are receiving contracts from CCGs and local authorities and the purpose (e.g. mental health) for which the contract has been placed. A dataset containing CCG information for the West Midlands for 2014-15 includes some 21 000 transactions but these cover only 775 distinct entities (including, as well as NHS Trusts and local authorities, private companies and third sector organisations) and from inspection only small numbers of these appear to be involved in contracts concerned with mental health care. We can therefore be confident that we can use this data to profile those organisations involved in mental health care delivery in our selected regions.

Studies of public service delivery must also take account of supply chains, whereby a contract may be placed with, for example, an NHS Foundation Trust, which then subcontracts elements of its work to other providers. Again, Foundation Trusts and NHS Trusts are also subject to disclosure regulations, so where we identify Trusts that receive funding for mental health provision, we will obtain data from them which will enable us to identify whether or not they have entered into subcontracting relationships with VS or other providers. We will do this through a sample of the records of the NHS trusts concerned with mental health provision in our selected regions for WP 2.

By using these two sources of information, the data will generate evidence about other VSOs operating in the mental health field beyond those identified through the Concordat. That data will be combined with the Concordat information to provide a sampling frame for further investigations. Based on previous studies of the third sector, which demonstrate high levels of concentration of resources in large national organisations (Backus and Clifford, 2013; Clifford and Mohan, 2016), we would expect to find a mix of providers. There will be a small number of relatively large national providers, possibly operating through regional networks or federated structures and visible in most if not all regions; eleven charities in the mental health field account for half of all spending, and 43 for two-thirds of it. There will then be larger numbers of regionally- or locally-focussed entities, possibly with distinct and established positions in their regions; and indeterminate numbers of smaller, local entities. The local ecology of these is what makes a regionally-focussed study essential, but we argue that the basic national profiling which we will undertake in the early stages of this work package is vital.

### **1) National survey of providers**

This data on registered charities and other VSOs will provide the sampling frame for organisations involved in mental health care service delivery and in receipt of CCG funding to do so. The next phase of our research involves generating more fine-grained primary data on the activities of voluntary organisations in this field. A structured electronic survey of voluntary sector providers will be developed to cover key themes:

- Organisational form
- Whether organisations consider that they are involved in the provision of crisis support, and the form it takes
- How crisis services are organised and delivered

- Target populations and reach
- Aims and intended outcomes of provision
- Operational model and details
- Challenges and key determinants of success in providing mental health crisis care
- Potential examples of positive practice.

The survey tool will combine tick boxes and opportunities to provide free-text responses, and will be piloted with a small number of VSOs (n = 6) before wider distribution, administered electronically. Response rates will be monitored and telephone follow-up will be employed to encourage response. The survey will be completed by telephone where a preference for this approach is expressed by respondents.

Quantitative data from the questionnaires will be used to generate descriptive statistics on the characteristics of the organisations providing services, their activities, resources and distribution. Qualitative free-text responses will be imported into NVivo for analysis and categorised into emergent themes and reported alongside the quantitative data. The analysis will draw on the typology of different opportunities for intervention, identified by the Crisis Care Concordat to map the different organisational forms, populations served and interventions of VSOs in mental health crisis care.

## **2) National stakeholder interviews**

A small number of stakeholder interviews (n = 20 - 25) will be undertaken with national stakeholders from the Department of Health; professional bodies, (Royal College of Psychiatrists, Royal College of Nursing, College of Social Work); Care Quality Commission; voluntary sector providers (e.g. Mind, Turning Point, Rethink) and service user and carer organisations (e.g. National Survivor User Network for Mental Health (NSUN)). They will be recruited via these organisations and the themes to be explored in these interviews will be:

- The nature of the contribution VSOs can make to mental health crisis care
- Effective ways of integrating this with statutory services
- Challenges and key determinants of success in providing mental health crisis care
- Potential examples of positive practice
- The future for mental health crisis care

These interviews will take place at an agreed location, most likely to be at the stakeholder's place of work. The interviews will be recorded and transcribed and NVivo 11 used to manage and code the data. Themes will be identified and comparisons between different types of respondents explored.

## **Work Package 2: Regional mapping**

WP 2 builds on the national scoping exercise to address Objective 2 and elicit detail on the different types of VSO provision in a regional context. There are three objectives in doing this: (1) to ensure that VSOs that do not describe themselves as crisis providers but nevertheless have this within their provision are included within the study; (2) to investigate the interface with statutory provision and there are advantages to doing this at a regional level because some VS providers will span the organisational boundaries of the local case



study sites; (3) to identify potential variations in access, and the role of VSOs, if any, in addressing these within each region.

Two regions will be identified and these will cover a large enough area to enable variations in the distribution and thus access to VS support in a mental health crisis to be investigated. The regions will be chosen to reflect a diversity of socioeconomic circumstances considered likely to be associated with varying levels of need for crisis support. Thus, they will include large metropolitan contexts experiencing great variations in deprivation / prosperity and demographic diversity and rural/semi-rural communities with relatively stable and prosperous populations and coastal towns with deprivation and a more transient population. There will be two data collection methods: (1) targeted interviews with commissioners and providers (n =10 per region) to identify additional activity that has not been picked up through the national scoping and explore the regional context for crisis care; the interface between VSOs and statutory services and what factors facilitate an effective crisis care pathways; (2) extending the e-survey (used in WP1) to those organisations that we identify from the interviews. In our analysis we will be able to compare larger organisations, identified through WP1, and smaller more local organisations (identified through WPs 1 and 2). This will permit us to provide a much more detailed picture of the types of services being studied, and of how crisis pathways are configured (see also WP 3). The data being assembled in WP 2 is, therefore, a mix of quantitative and qualitative information. We anticipate using further quantitative data, on the activities and resources of regional and local organisations not evident in the national quantitative mappings, and we also anticipate more detail on the roles, resources and relationships of these organisations, of a qualitative kind being drawn from interviews and documentary sources including:

- What voluntary organisations are actually providing
- How they are commissioned or otherwise funded
- How they interface with public sector (and for-profit) agencies, particularly the principal mental health trusts, and how care pathways work in the different regions
- What are their experiences? E.g. what policies are there, how does funding work, what works well, not well?
- The role of commissioning agencies.

Regional investigations will also require strong commissioner and provider input, both to identify what sources of support are available, assessments of the quality of services, management and funding arrangements to delivery support, and capacity issues such as the availability of financial and human resources. The latter two points are highly relevant in a context in which more is expected of the VS, because the capacity of communities, and their ability to care, very greatly. As is well-established VS research, there are variations between communities in the distribution of VSOs and of volunteers, while organisations in poorer areas have fewer resources than their counterparts from wealthier places (Mohan and Breeze, 2016; Clifford, 2012). Thus discussions need to focus on how capacity might vary from one place to another.

The resultant data will be analysed to provide an analysis of variation within and between the two regions, the factors that have shaped this and the potential impact on crisis care delivery at a local level. This detailed regional analysis will refine and add to the initial taxonomy

developed in WP 1, giving researchers and policy makers a guide to understanding the main ways in which crisis care can and is commissioned and provided in different places. This taxonomy will also be used as a sampling frame to guide the selection of case study sites for detailed data collection at a local level.

### **Work Package 3: Case studies of the voluntary sector contribution at a system level**

Work package 3 investigates the contribution of the voluntary sector to crisis care at a local system level, addressing Objectives 3 and 4. This work package focuses on investigating how the voluntary sector elements of the crisis care system work together, and with statutory provision; and identifies the challenges and determinants of success from the perspective of commissioners, voluntary and statutory sector providers, volunteers, service users and carers.

Four contrasting case study sites will be identified including one from each of the two regions from the output of work packages 1 and 2, using two key sampling criteria:

- a) Geography: case study sites will be selected to include voluntary sector provision in both rural and urban settings in England, and include cases with a highly diverse population from BAME communities.
- b) Types of voluntary sector provision: cases will be selected to contrast in terms of the types of voluntary sector provision identified from work packages 1 and 2, e.g. a case with a crisis house and one without, and size (e.g. local versus national).

In selecting our case study sites, we will take a realist approach to sampling (Emmel, 2013) because we recognise that case study research moves back and forward between 'ideas' and 'evidence' and therefore needs to be tested out and refined as we encounter the data. While we have formulated criteria for information-rich case study sites (i.e. sites that have different models of VS provision for different populations), this may be reformulated as the research progresses and data emerges on information rich cases (Patton, 2002). Within each case study site, data to understand how the crisis care system operates as a whole will be gathered to identify how the different organisations providing crisis care are working together at a local level and what factors facilitate effective integration so that service users and their carers experience an easy journey to accessing appropriate support. We will seek to explore the extent to which small-scale community groups also assist in the provision of crisis support, in order not to rule out consideration of innovative local developments.

In each case study site, three methods will be used for data collection:

- 1) Semi-structured interviews with key stakeholders (n =15 – 20 per site, 60 – 80 in total). These stakeholders will include CCG and Local Authority commissioners; voluntary sector providers; NHS Trust managers, mental health and social care practitioners (including hospital and community-based staff: psychiatrists, nurses social workers, peer support workers etc.) involved in providing mental health crisis support; front line staff, notably the police and GPs. Participants will be identified and recruited from information collected in WP 2. The lines of inquiry for these interviews will cover:
  - The crisis needs being met by different elements of the crisis care system
  - How well the system responds to the diversity of need of the whole population

- How these different elements work together to provide an integrated crisis care pathway
  - The quality of current arrangements
  - The key challenges faced and how these are being addressed
  - The current and likely future pressures on the services.
- 2) Two focus groups will be held, one targeted at service users and one at carers to understand experiences of voluntary sector provision and how this fits within the crisis care system. The focus groups provide an opportunity for a ‘collective conversation’ (Kamberelis & Dimitriadis 2008: 375) with service users and carers as to their experience of crises and the crisis care pathway. This data will provide an important reference point for how these meanings are enacted in the response of VSOs and the wider system.

Focus group participants will be recruited via the VSOs, service user and carer organisations, local authorities and NHS mental health Trusts in each case study site. Steps will be taken to ensure diversity in the sample in terms of demographic characteristics, range of mental health problems and crisis experience. All participants (n = 48) will be invited to complete a brief questionnaire at the end of the focus group (or interview in WP4) to capture brief demographic details, which will include information about their mental health condition and use of services.

Inclusion criteria:

- Experience of using voluntary sector crisis care within the past two years
- Age 16 years plus
- Capacity to be involved in a research interview

Exclusion criteria:

- No experience of using voluntary sector crisis care within the past two years
- Under the age 16 years plus
- Lacking capacity to be involved in a research interview

Interpreters and signers will be recruited, as appropriate, to ensure that the participants are a diverse sample. The lines of inquiry for the focus groups will cover:

- Experiences of the crisis system
- How this experience contributed to recovery
- What worked well
- What needs attention
- Differences in experience between engagement with the voluntary and statutory sectors.

The focus groups will be co-facilitated by a peer researcher with experience of a mental health crisis. The focus groups will be recorded and transcribed and imported into NVivo 11 for coding.

- 3) A survey of local views of key informants using a questionnaire to provide an assessment of how well the crisis system is working as a whole, based on a questionnaire developed in a US context by Morrissey et al. (1994) and informed by a literature review of measures of system integration, undertaken by the specialist library at HSMC. It will provide data on the different stakeholder perspectives on the quality and the adequacy of the local crisis system, with questionnaire items evaluating both individual organisations and the system of organisations. There will also be items rating how well the crisis care pathway is integrated. The survey will be sent to key informants in the case study sites, identified from regional mapping in WP2 and semi-structured interviews in WP3. This broad systems evaluation is relatively innovative and it will provide a useful adjunct to the interview data from WPs 3 and 4 (see Morrissey et al. 2005 for example). This questionnaire will be piloted with a small number of different stakeholders and administered either electronically or by post.

The questionnaire data will be analysed using descriptive statistics and the qualitative data analysed, as previously, to identify the main themes influencing how the voluntary sector is contributing to crisis care at a local level.

#### **Work Package 4: Case studies of the voluntary sector contribution at an individual level**

Work package 4 investigates the contribution of the voluntary sector to crisis care, addressing Objectives 3 and 4 at an individual level to map crisis care trajectories for individuals in each site to develop a granular picture of this journey to illuminate the voluntary sector contribution for individuals experiencing a mental health crisis and to understand how the interface between the person experiencing a crisis and different services is shaped. This will provide a valuable independent perspective with which to contrast the testimony of VSO respondents – i.e. a user perspective which may be critical of elements of the crisis care trajectory. The aim is to recruit 12 service users per case study site. Service user participants will be recruited via voluntary sector organisations (VSO), local authorities NHS crisis services and service user organisations. As far as is possible the sampling will be purposive to ensure that the final sample is diverse both in terms of demographic characteristics (gender, ethnicity and age) and experience of the use of VS and NHS services. The VS and NHS Trusts will be approached in the case study sites with information about the study and their agreement to participate. The VS organisations will be asked to provide an anonymised list of people who have used the services and meet the inclusion criteria (as below). If this is not possible, the participating NHS Trusts will be provided with a list of inclusion criteria, for them to approach the participants, provide them with the information and our contact details should they want to take part, or seek their consent to pass on their contact information to the research team. We will request that they pay attention to diversity in terms of age, gender, and ethnicity. This will also be supplemented by convenience sampling to ensure that the sample includes people with different crisis experiences (e.g. first time, repeated crisis, psychosocial crisis, symptoms of a mental illness). VSOs will be asked to send or give a letter to potential participants. The letter will provide details about the study and will ask the potential participant for permission for the research team to contact them directly. There will be a stamped addressed envelope (SAE) for the potential participant to reply directly to the research team.

Once participants have come forward, they will be given the participant information sheet, which provides information about what is involved, and makes clear the arrangements for ensuring confidentiality, protection of their data, their right to withdraw up to a month after the interview and reimbursement of expenses and a fee in recognition of their time.

As necessary, the information will be available in different formats and an interpreter available if required for people who are not fluent in English or require a signer.

### ***Inclusion criteria***

As the aim is to gather information about the current operation of the VS in relation to crisis care, service user participants should have experienced a mental health crisis that led them to access a VS service and have also had an episode of NHS care, which could be through primary or secondary mental health services. Therefore, the criteria for inclusion of service user participants are:

- Experience of using VSOs and an episode of NHS care within the last 12 months (extended from 6 months) to support them with crisis management
- Age 16 years plus
- Capacity to be involved in a research interview.

### ***Interviews***

For each person, information on the crisis care trajectory will be gathered through separate narrative interviews with the person, their carer (subject to service user consent) and the voluntary sector practitioner. Consistent with narrative approaches to interviewing, there will be a focus on encouraging participants to tell stories about their experiences of and engagement with current support services for mental health crises, (Reissman, 2008). (Maynard-Moody and Musheno 2003), including:

- The nature of the mental health crisis
- Which services were used, when and what for
- Access to these services and factors influencing this
- Experience of these different services
- The difference using these services made to individual capacity to deal with the crisis
- What the person would do in the event of a mental health crisis in the future.

The interviews will take place at a mutually convenient location and last between 60 and 90 minutes. There will be 48 service user participants in total (12 per case study site) and, subject to their consent, a carer or family member and practitioner. Not all service users will have a family member or carer or consent to them being interviewed and practitioners may well relate to more than one service user and so, we anticipate that the total number of service user/carers/practitioner interviews will be in the region of 60-80.

For a sample of six service user participants in each study site, repeat interviews will be taken 6-9 months later to ensure we have fully captured the trajectory and are able to analyse shifts in the perception of the experience of crisis. Repeat interviews better capture people's changing needs (Murray et al., 2009); build trust and rapport with participants from

vulnerable populations (Vincent, 2013) and gives people's narratives internal validity (Judge et al., 2008).

Interview data will be recorded and transcribed using NVivo 11 to assist in data management and analysis. Participants will also be asked to complete a brief questionnaire to provide demographic details (age, ethnicity, disability, sexual orientation, length of time in contact with MH services, services used and the number of times they have been subject to the MH Act).

## **Data Analysis**

The analytic strategies reflect the research objectives to understand the contribution of VSOs in responding to people experiencing mental health crises.

1. Classification of the organisations and activities undertaken by VSOs to develop a taxonomy of the range of contributions and use as a sampling frame for selection of the case study sites.
2. A thematic analysis of national stakeholder interviews to identify additional VSOs and refine the taxonomy.
3. Content analysis of documents and commissioning strategies to identify the VSO contribution and levels of investment.
4. Interview and focus group data will be analysed using the Framework method (Gale et al., 2013) (2003) to identify key themes and investigate relationships between different themes and different types of participant. This will include understanding the temporal nature of the experience of a mental health crisis.
5. Exemplar care pathways will be mapped to provide a detailed understanding of the interface between VSOs and NHS, Local Authority and other public sector services.

The data will be explored in different ways. All data will be uploaded into NVivo 11, a qualitative research software package. The data will be coded in NVivo using codes developed by the research team from the research objectives and an initial review of the data. These codes will be used to classify the data and compare data across different participants, case study sites and types of VSOs. The various stages of the project will be integrated fully. WP 1 will inform the foci for the regional mapping (WP 2), which will identify and deepen the focus for the case studies (WPs 3 and 4). The case-studies will enable us to address the research objectives in greater detail. Furthermore, WPs 1 and 2 will inform the sampling strategy and provide a context for the analysis of findings from WPs 3 and 4. The analysis will, therefore locate the qualitative data on experiences and outcomes within the framework provided by the quantitative data and will be integrated in the reporting of the findings.

Data synthesis will be an iterative process focused on the research objectives and exploring the relationships and tensions between the following variables:

- The type of voluntary sector provision and activities
- The type of crisis needs
- Individual respondent characteristics and methods

- Organisational form and commissioning arrangements.

This will be summarised in a matrix to provide a basis for a research team workshop to bring together the various analyses to answer the research questions; identify patterns and similarities between different data sources and accounts and to capture the different interpretations of academic researchers and co-researchers.

All members of the research team will conduct the data analysis, which will be an ongoing process as the various work packages are completed. The validity of the coding will be checked for a 10% sample of the interviews by a second member of the team, independent of the data for the data analysis of that particular sample. Any discrepancies in coding will be referred to the Chief Investigator for review. The data will be stored on a University of Birmingham computer and be password protected.

## **PLAN OF INVESTIGATION AND TIMETABLE**

Start date: 1st November 2016

End date: 31st January 2019

Duration: 27 months

Months 1-3: recruit Research Fellow, recruit and train co-researchers; apply for HRA and University of Birmingham ethics approvals; establish and convene steering group; develop research instruments.

Months 2-10: WP 1: generate national listings of relevant organisations, conduct national survey, undertake national interviews; consult steering group; analyse survey data; select regional study sites.

Months 10-14: WP 2: regional mapping; select and negotiate access to case-study sites; convene steering group

Months 12-23: WPs 3 and 4: collect case study data collection at system and individual level; convene steering group.

Months 22-27: analyse case-study data; triangulation with data from work-packages one and two; draft report; run stakeholder events; complete final report; deliver conference and written outputs.

After completion of the project, articles will be prepared for journal articles. Once these have been completed, the data will be deposited in the University's Research Data Archive for ten years.

## **APPROVAL BY ETHICS COMMITTEES**

Standards of good practice for research will be followed (Social Research Association, 2003) and the project will be undertaken in compliance with the Data Protection Act and University of Birmingham policies relating to the conduct of research. This project will require ethical approval by the University of Birmingham Humanities and Social Sciences (HASS) Ethical Review Committee for WPs 1 and 2, and the Health Research Authority (HRA) for WPs 3 and 4.

The main ethical issues that arise from this research are achieving voluntary informed consent, confidentiality, anonymity and privacy and discussion of distressing or upsetting topics.

#### **a) Consent**

Written consent to participate will be obtained from all participants prior to their participation in either a focus group or interview by a member of the research team. Information about the study will have been sent to participants by the research team via the VSO or NHS, as appropriate, in advance and will be explained verbally including an explanation about their right to withdraw at any stage without having to give an explanation. Capacity to participate in the study will be assumed unless a potential service user participant clearly demonstrates that they lack the capacity to do so, using a range of methods to establish this (Calveley, 2012) reflecting current legislation and good practice.

#### **b) Confidentiality and data protection**

Participants will be advised that what they say will be treated as confidential, unless they reveal potential harm to themselves or someone else. The consent form includes permission to contact a health professional and if the participant agrees a health professional will be informed of the person's participation in the study.

Care will be taken to maintain the confidentiality of records and prevent disclosure of identities of research participants, using an ID code for each participant. Contact information will only be kept for as long as practically necessary and then destroyed or, as in the case of computer files erased from all computers at the Universities on completion of data collection. We will ensure all researchers treat information with care at all times and in accordance with accepted codes of conduct and the University of Birmingham's Data Protection policy.

#### **c) Risks and hazards**

It is not anticipated that the interviews should result in any adverse reaction. However, an agreement about the arrangements that need to be in place to manage any adverse reaction will be made with the organisations at each of the sites before focus groups or interviews take place, and the local collaborator will be informed. It is also possible that during the course of the research that unmet needs for support in a crisis will be identified and in such instances the CI will inform the local collaborator, as well as a named health professional as appropriate.

In the event of anyone becoming distressed during an interview or focus group, this will be brought to a close and only restarted if or when the individual concerned feels ready. A member of the research team will discuss with the person concerned what support they need and who they would like to be contacted. A list of local organisations providing support to people in a mental health crisis will also be provided, should any participant request information on services available.

The safety of the researchers is important and risks to the interviewer will be assessed in determining the location for the interview and discussed with a key member of staff at the site as appropriate. In some instances interviews will be undertaken in people's homes and these will be undertaken in pairs. A safety policy and a lone working policy will be in place.



#### **d) Serious breach**

If a serious breach of the protocol occurs, e.g. data loss or compromise, this will be reported to the REC and sponsor as required, in line with the University's procedures and code of conduct for research.

### **PATIENT, SERVICE-USER AND PUBLIC INVOLVEMENT**

There will be service user involvement in all aspects of this study, via Suresearch, a network, of over 100 mental health service users, survivors and their allies involved in research and education. Based at the University of Birmingham, Suresearch<sup>3</sup> is a group of service users with research training and experience of undertaking research and advising academic researchers and postgraduate students about the design, delivery and dissemination of their projects (Davis et al., 2014). Suresearch members, who bring lived experience of having a mental health crisis, have influenced the proposal and refined the research questions and methods through involvement in research team meetings, the PI attending Suresearch meetings and commenting on the full bid. This input has influenced the design and highlighted how it is important to understand the crisis care at an individual service user level as well as the system level.

PPI will strengthen the credibility and validity of the research as we will be drawing on a range of direct experiences of crisis support and different interpretive frameworks, and ensuring that service users, carers and members of the public are active participants in the research process, able to shape, change and challenge the research process and the knowledge development (Christensen and Prout, 2002). Service users, carers and members of the public will be actively involved as follows:

**As co-researchers:** four people with lived experience of a mental health crisis will be recruited as co-researchers, via Suresearch, and be involved at all stages of the research, including analysis and dissemination, as well as data collection. Recruitment, training and involvement of co-researchers, including payment and reimbursement of expenses, will follow best practice guidance (Branfield et al., Beresford and Carr, 2012; Beresford, 2013; NIHR Clinical Research Network Mental Health, 2014; INVOLVE, 2015). Each co-researcher will be buddied with an academic for ongoing support and supervision and there will be regular team meetings to share ideas. Training will be provided, as necessary, and cover:

- Ethical considerations and good practice in research
- Designing research questions
- Collecting data through interviews and focus groups
- Analysing data
- Reporting findings, including effective dissemination for impact.

Co-researchers will be paid an hourly rate, in addition to expenses, whilst recognising that benefit rules can be a barrier (Rickard and Purtell, 2011).

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<sup>3</sup> More information available at: <http://www.suresearch.org.uk/> [accessed 251016].

**Members of a Service User Reference Group:** to act as a critical friend, to inform the development of the research tools and lines of inquiry and comment on emergent findings. This group will consist of eight people with representation from the public, carers and mental health service users, and specific attention will be paid to ensuring that diverse groups are represented.

**Representation on the Study Steering Group:** members of this Service User Reference Group will be represented on the Project Steering Group, which will provide overall governance of the project and ensure that the key milestones are met as well as providing expert advice.

The National Involvement Partnership's National Involvement Standards (National Survivor User Network for Mental Health (NSUN, 2013) will be used as a framework for reflecting on the quality of involvement through the course of the study.

## **RESEARCH GOVERNANCE**

A Study Steering Group will provide oversight, harness expertise and facilitate dissemination through members' networks. This group will meet four times and will be convened and/or consulted at key stages in the development of research tools, analysis of the findings, and commenting on the research report and dissemination plan. The membership includes representation from:

- Crisis Care Concordat
- Voluntary sector organisations
- Mental health professionals
- Commissioners
- Service users, carers and members of the public
- Service User Reference Group
- Project team, including the Principal Investigator.

Additional expertise will be co-opted as necessary.

## **REGULATORY REVIEW & COMPLIANCE**

For the case study sites in WPs 3 and 4, the Chief Investigator will ensure that appropriate approvals from participating organisations are in place. For any amendment to the study, the Chief Investigator in agreement with the sponsor will submit information to the appropriate body in order for them to issue approval for the amendment. The Chief Investigator will work with sites (R&D departments at NHS sites as well as the study delivery team) so they can put the necessary arrangements in place to implement the amendment to confirm their support for the study as amended.

## **DISSEMINATION**

### **Dissemination policy**

On completion of the study, the data will be analysed and tabulated and a Final Study Report prepared and will be available at on the University of Birmingham website and

published by NIHR. All participants will be sent a summary of the findings with details on how to access the full report.

The project will most likely not produce any Commercial Intellectual Property; however the research will produce materials of interest to the health and social care community and NIHR, including:

- An end of project report to NIHR
- A set of PowerPoint slides presenting the main findings from the research freely available
- A database of VSOs providing mental health crisis care available via the Third Sector Research Centre
- Guidelines on commissioning and working with VSOs to provide effective mental health crisis care.
- A practical guide drawing out the main policy and practice implications of the research
- Journal articles in high impact academic and practitioner journals.

#### **Authorship eligibility guidelines and any intended use of professional writers**

All members of the research team who contribute to the writing will be granted authorship on the final study report. The contribution of other research team members to the study will be acknowledged.

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## APPENDIX 1: RESEARCH DESIGN AND PLAN

