The contribution of the voluntary sector to mental health crisis care: a mixed-methods study

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Disclaimer: This report contains transcripts of interviews conducted in the course of the research and contains language that may offend some readers.

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Scientific summary

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Scientific summary

Background

The relationship between the voluntary sector and public services, and how their contributions should be integrated to provide a whole-system response, are current and pressing concerns. The provision of support to people experiencing a mental health crisis provides a useful exemplar to investigate this relationship. Mental health crises have been conceptualised as a 'turning point', with both risks and constructive potential. The policy focus has typically framed mental health crises in a biomedical discourse, requiring rapid psychiatric assessment and intervention, although current policy and service users advocate for a wider range of support, including provision by the voluntary sector and community organisations. The failure of the current arrangements for mental health crisis support in England has been highlighted by the Care Quality Commission, and a Mental Health Crisis Care Concordat was introduced to facilitate improvements in access to high-quality and effective support. The voluntary sector is identified as an essential element of the crisis system and is increasingly expected to contribute to mental health crisis care pathways. However, there is a lack of evidence for the role of voluntary sector organisations and how they might best contribute to mental health crisis care.

Literature review

A systematic review was outside the scope of the study, but a literature review was undertaken to identify evidence for the contribution of voluntary sector organisations to mental health crisis care and to map the key concepts.

There is a paucity of evidence on the contribution of the voluntary sector to mental health crisis care. The majority of papers identified in this literature review were concerned either with crisis houses or with the emotional or practical experiences of crisis. The grey literature identified the particular role of the voluntary sector in providing longer-term holistic support in mental health care, and a compassionate and human response. The contribution of voluntary sector organisations as an alternative to inpatient care was identified but there is scant research on the contribution of the voluntary sector to other parts of the crisis continuum, namely access to support before a crisis or recovering and staying well. Consequently, there is a gap in the understanding of the 'whole system' of crisis support and, in particular, of how relationships between the voluntary sector and the public sector may work across a geographical area larger than that covered by a single organisation or service. A key contribution of this study is that it addresses this knowledge gap by identifying what is being provided by the voluntary sector to those experiencing a mental health crisis, where it is being provided and to whom.

Aim

The primary aim of this research was to identify the contribution of the voluntary sector to mental health crisis care and to identify the implications for policy and practice to strengthen the crisis care response in mental health. It provides a platform for subsequent research to evaluate the effectiveness of different voluntary sector models. To this end, the project had five key research objectives to:

1. identify the different types of voluntary sector support being commissioned and/or provided in response to the needs of people experiencing a mental health crisis
2. develop a taxonomy of different voluntary sector organisations and to describe the scope (e.g. national, local) and service models of the voluntary sector support available, including characterising their relationships with public sector provision and the populations served

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3. investigate the experience of a mental health crisis of different stakeholders, including individual service user needs in a crisis, and to investigate how voluntary sector organisations contribute to meeting these needs as part of the overall crisis care system
4. identify the factors and processes that facilitate the successful contribution of the voluntary sector to effective crisis care pathways
5. identify policy and practice recommendations to strengthen the mental health crisis care response, including the implications for commissioning and the interface with mental health services provided by the NHS and local government.

The scope of the study was mental health crisis care in England. Clinical outcomes and comparisons with different types of service provision were beyond the scope of this study and, therefore, provide a focus for further research in this area.

Research design and methods

The design used multiple methods and involved four work packages. Work package 1 assessed the contribution of voluntary sector organisations to mental health crisis care through a national survey of voluntary sector organisations, supplemented by interviews with national stakeholders. Work package 2 involved detailed mapping of voluntary sector organisation provision, including capturing small-scale community-based initiatives in two contrasting regions to understand variations in access. From these two work packages, a taxonomy of the contribution of the voluntary sector to mental health crisis care was developed, and this provided a sampling frame to select four case studies. The focus for these case studies (work packages 3 and 4) was to investigate the contribution of voluntary sector organisation provision to mental health crisis care at both a system level (work package 3) and an individual level (work package 4). The study sites were located in North-East England, the Midlands, East England and London and were selected to capture demographic diversity and different types of voluntary sector provision. In these case study sites, interviews with stakeholders – including commissioners, mental health professionals, voluntary sector organisations, and user and carer organisations – and focus groups with service users and carers were conducted to understand the mental health crisis care system and the relationships between the different elements. Forty-seven interviews with people who had experience of using both NHS and voluntary sector services were undertaken to understand their crisis journey and how they had used different services. Where possible, and with their consent, a carer or family member was invited to take part in an interview to offer their perspective on this journey. Approximately half of the service users in the sample were re-interviewed to understand the temporal dimension of a crisis, the support they had accessed and its impact.

Analysis

Focus groups and interviews were digitally recorded and imported into NVivo 12 (QSR International, Warrington, UK) for analysis. The analytic strategies reflected the research objectives and involved:

- classification of the organisations and activities undertaken by voluntary sector organisations to develop a taxonomy of the range of contributions and to use this as a sampling frame for selecting the case study sites
- a thematic analysis of national stakeholder and regional interviews to identify additional voluntary sector organisations and refine the taxonomy
- within-case and cross-case analysis of interview and focus group data to identify key themes and investigate relationships between themes and different types of participants
- mapping individual journeys to provide a detailed understanding of crisis journeys.

Data synthesis was an iterative process focused on the research objectives and it explored the relationships and tensions between the following variables:

- the type of voluntary sector provision and activities
- the conceptualisations of a crisis and the range of crisis needs
- individual respondent characteristics and crisis journeys
- the location in the mental health crisis system and the relationship with public sector services
- the organisational form and commissioning arrangements.

Workshops were held with the research team, the Study Reference Group and the Study Steering Group to bring together the various analyses to answer the research questions, identify patterns and similarities between different data sources, and capture the different interpretations of academic researchers and co-researchers.

Public and patient involvement

People with experience of a mental health crisis were extensively involved in the conduct of the research, as co-researchers and as members of the Study Reference Group and the Study Steering Group. Public and patient involvement in the study was independently evaluated and commended. The evaluation also identified areas in which involvement processes could be strengthened, including the arrangements for payment and support.

Ethics approval

Ethics approval for work packages 1 and 2 was granted by the University of Birmingham Humanities and Social Sciences Ethical Review Committee (RG16-153). Ethics approval for work packages 3 and 4 was granted by West of Scotland Research Ethics Committee 4 (18/WS/0022) and was approved by the Health Research Authority (IRAS 211953). Research governance bodies for the relevant NHS trusts also reviewed the application to confirm participation.

Findings

Experiences of a mental health crisis

Service user participants described the intensity of the distress they experienced when in a mental health crisis, and the overwhelming nature of these feelings was associated with needing to be understood and to be treated with compassion and humanity. The narratives identified the experience of a mental health crisis as a biographical disruption: an intense and extreme experience that disrupts everyday life and potentially has far-reaching consequences. A corollary of this is that the experience, and the response, cannot be disconnected from the personal and social context of living. This conception contrasts with the narrow definition of a mental health crisis as an episode requiring an urgent response, which means underlying difficulties may not be addressed. Differences in the conceptions of a mental health crisis are enacted through the policy discourse, service configuration and professional behaviour, all of which may influence the contribution of voluntary sector organisations and the relationship with public sector services.

The contribution of the voluntary sector to mental health crisis support

We identified a wide range of voluntary sector organisation activities contributing to mental health crisis care, and distinguished five types of voluntary sector organisations. Type 1 voluntary sector organisations are most commonly identified as having a role to play in mental health crisis care because they take part in providing an urgent response to someone in crisis and are formally commissioned by the public sector to do so; access is, generally, via the NHS. Type 2 voluntary sector organisations are general mental health organisations that contribute in terms of prevention, recovery and improving quality of life for people

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experiencing a mental health crisis. Types 3 and 4 voluntary sector organisations offer specific skills and knowledge in engaging with and responding to people who may not access statutory mental health services or who are experiencing a specific life event. Type 5 voluntary sector organisations are social and community organisations that are often 'under the radar' but provide an important source of social connection and occupation.

We identified that the voluntary sector is distinctive and can be characterised by its relational socially oriented style of operation. Many participants commented on the compassion, humanity and kindness they encountered when using voluntary sector organisations, and they valued the blurring of roles between staff, volunteers and peers. Voluntary sector organisations compared favourably with public sector services and were described as being more responsive and flexible to service users' needs.

The accessibility, adequacy and quality of voluntary sector mental health crisis support

The contribution of the voluntary sector is shaped by its evolution, the capacity of the wider mental health system and the relationship between the voluntary sector and public sector services. Variation and inequalities in access to voluntary sector provision were identified for type 1 voluntary sector organisations (i.e. crisis specific), with people living in rural areas particularly disadvantaged by a lack of provision. Inequalities in access for other groups were identified, namely black, Asian and minority ethnic communities, people who use substances and people who identified as having a personality disorder. Access to type 1 voluntary sector organisations is typically restricted by NHS services such that people with higher needs or presenting with greater risks are assessed by mental health staff and diverted to other services. Self-referral, a rapid response and face-to-face support were valued by service users, and it is notable that some people preferred to use voluntary sector organisations that were independent of the public sector. The voluntary sector services in our study were widely appreciated and evaluated positively. Although this is primarily a descriptive study, we were able to identify a range of positive impacts of voluntary sector support, including enabling people to re-evaluate their lives, develop strategies for coping with distress and develop better support networks.

The relationship between the voluntary sector and public sector

The crisis system in the different sites was generally underdeveloped, although the Crisis Care Concordat had stimulated some redesign. This was most advanced in one site, in which an NHS helpline with a first response service attached and a route through to a safe space had been introduced. When the relationship between type 1 voluntary sector organisations and NHS services was most developed, there was evidence of a mutual understanding of each other's role. The awareness and appreciation of other types of voluntary sector organisations, however, was often less developed and there was a general lack of up-to-date information about what was available. Effective collaboration at the level of the individual service user was focused around providing an urgent and immediate response and there was little evidence of a coherent pathway, although voluntary sector organisations and NHS services would signpost and/or refer to each other. Both the absence of a preventative approach and a lack of continuity to enable people to address the relevant contextual factors were evident.

The contribution of the voluntary sector was widely appreciated and participants were often critical of their experience of NHS services, the lack of responsiveness of crisis resolution home treatment teams, and the high thresholds to access services and long waiting lists, stating that these aspects compromised their access to crisis support. They were also critical of dismissive and insensitive attitudes in public sector services and referred to a mistaken view of agency, with responsibility shifted back to the person experiencing the crisis.

The closeness of the relationship with public sector services varied, ranging from voluntary sector organisations that are committed to maintaining their independence to those closely aligned with NHS crisis services that determine who will access the voluntary sector organisation. Some voluntary sector organisations provided a radical critique of public sector provision and maintaining this, in a context of competitive tendering, may prove challenging.

Our findings indicate that the contribution of the voluntary sector to improving the crisis care system could be better realised through (1) a better appreciation of the voluntary sector contribution, (2) clear standards for crisis support, so that people know what support they can expect, (3) a demonstrable commitment to equity and addressing variations in access to crisis care and (4) investment in the voluntary sector.

The development and sustainability of the voluntary sector

Respondents recognised the centrality of commissioning in regulating and delivering funding and indicated that it must be improved. However, a bigger challenge came from those who suggested that the commissioning approach is fundamentally flawed, in particular that commissioning is actively inhibiting or damaging the quality of services delivered in the voluntary sector. Key recommendations for improving commissioning emphasised more resources, more integrated commissioning and consequently joined up services, greater recognition of what the voluntary sector offers, how its role in commissioned services can be sustained, and greater involvement of the voluntary sector and communities (including specialist health and protected characteristic communities) in the commissioning cycle.

Conclusions and implications

A broader understanding of the nature of mental health crises and what the voluntary sector has to offer to mental health crisis care is needed. There needs to be easy access to 24/7 non-clinical alternatives to inpatient provision. This transformation in mental health crisis services needs to include the expertise of the voluntary sector and be designed to meet the diverse needs of the local population. Service users and carers from all communities need to be involved in co-commissioning and co-producing mental health crisis care. The NHS, local authorities and the voluntary sector need to establish how they can collaborate and ensure longer-term funding for the voluntary sector.

This study was a descriptive study and it provides a platform for further research on the contribution of the voluntary sector to mental health crisis care and, in particular, the evaluation of the outcomes and cost-effectiveness of different models of voluntary sector provision.

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