Trinity College Dublin
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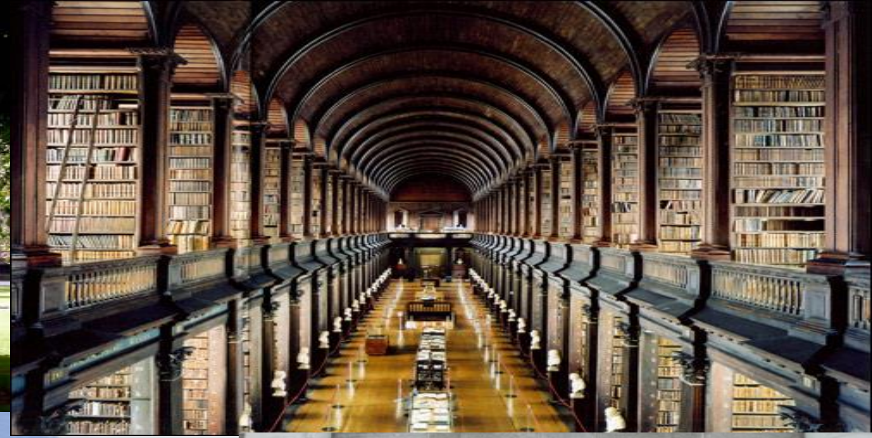
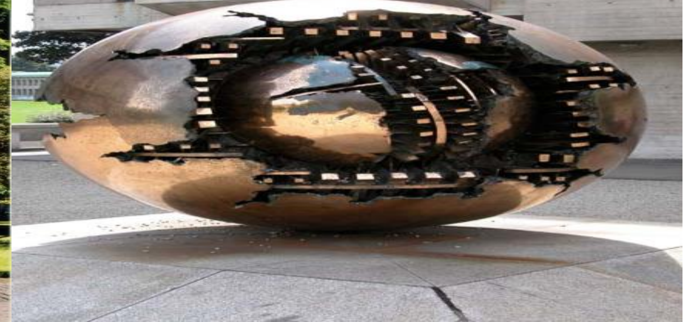
Co-production in policy, practice research and education: ripples or ravines

Professor Agnes Higgins

14th March 2023





Co-production in practice and research: ripples or ravines

01

Co-production Origins

02

Values and aspirations

03

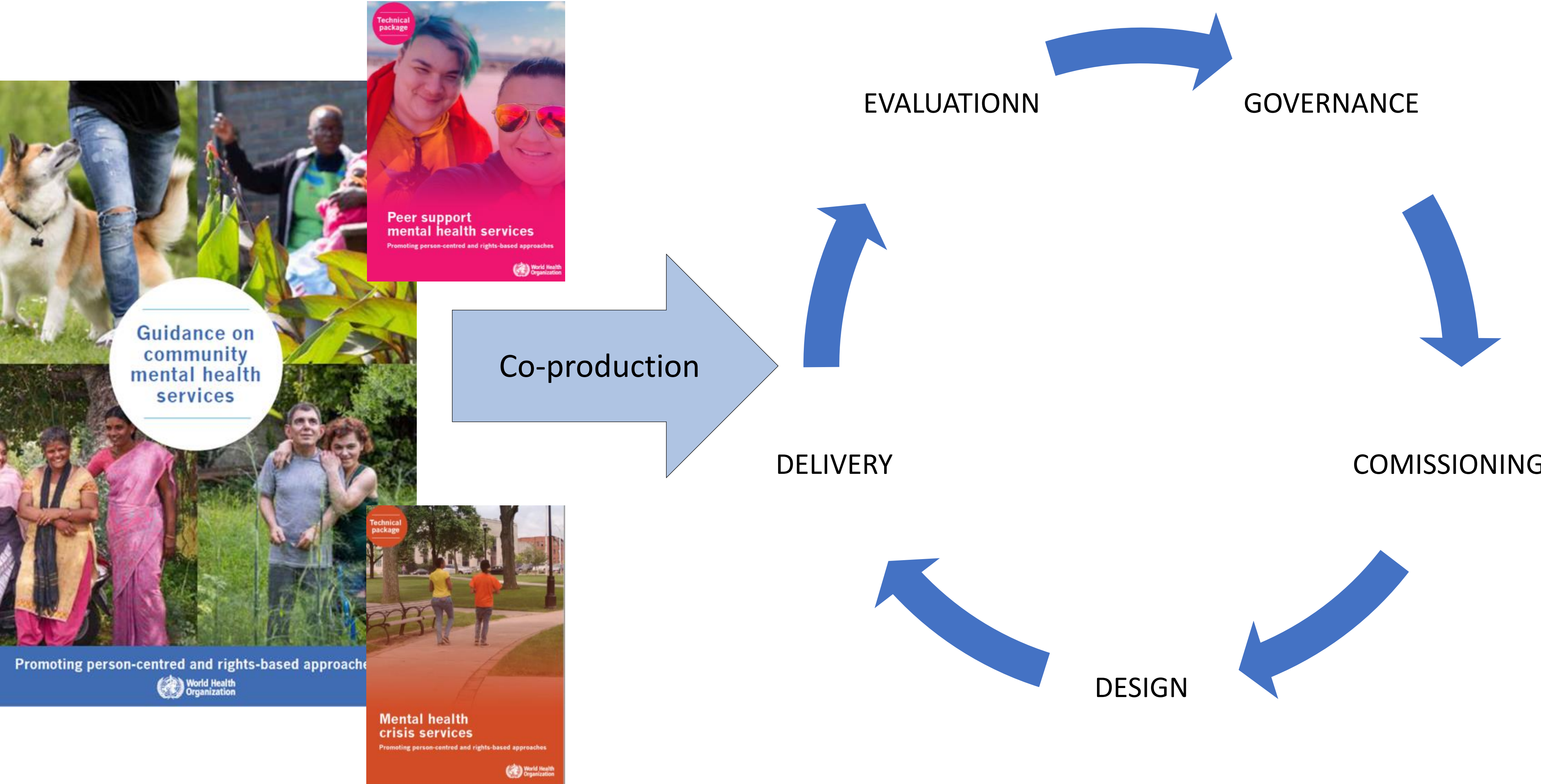
Current state
Outside/within MH system
'Creating ripples ??'

04

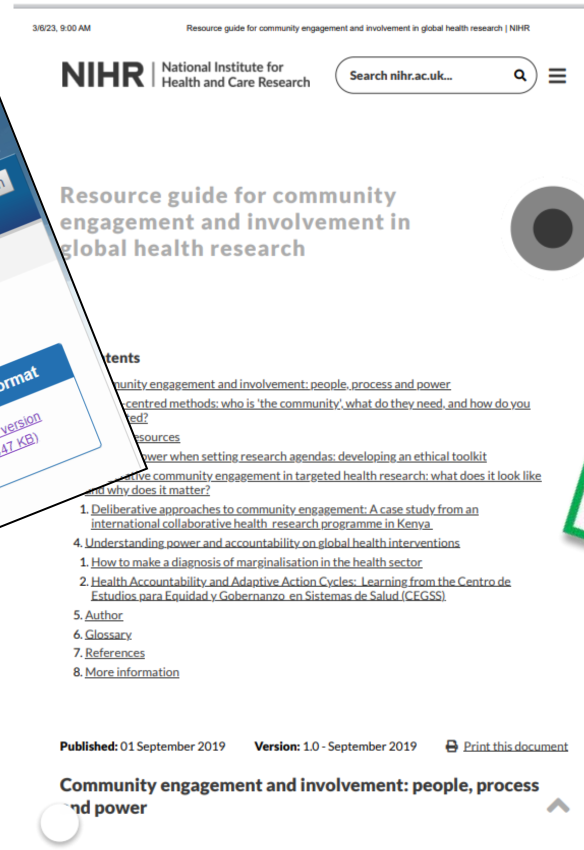
Refection's of future
'Creating a ravine'

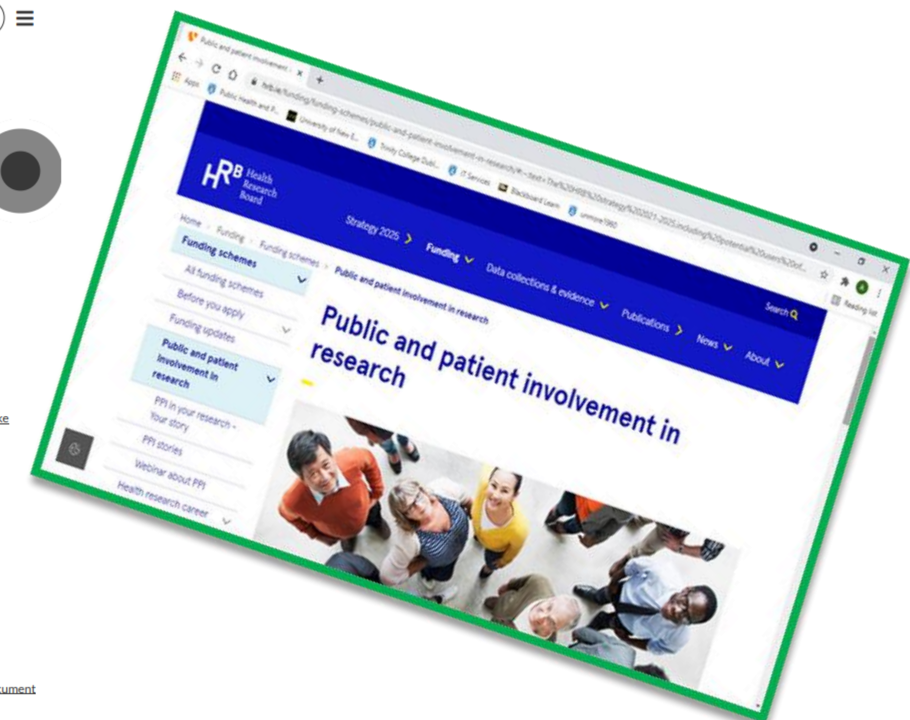
Stuðlagil Canyon can be found in East Iceland in the Glacier Valley also known as Jökuldalur

Co-production: latest trend in Participatory Zeitgeist

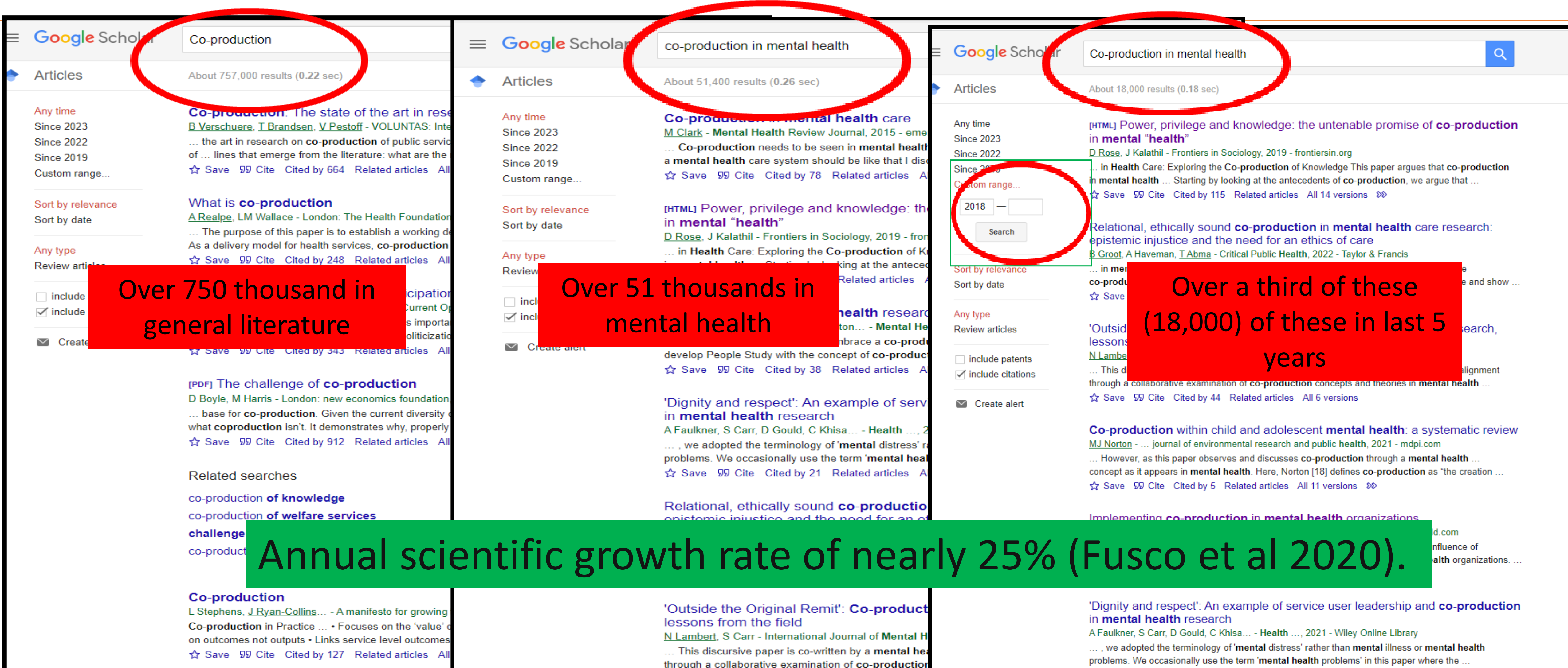


Co-production: research

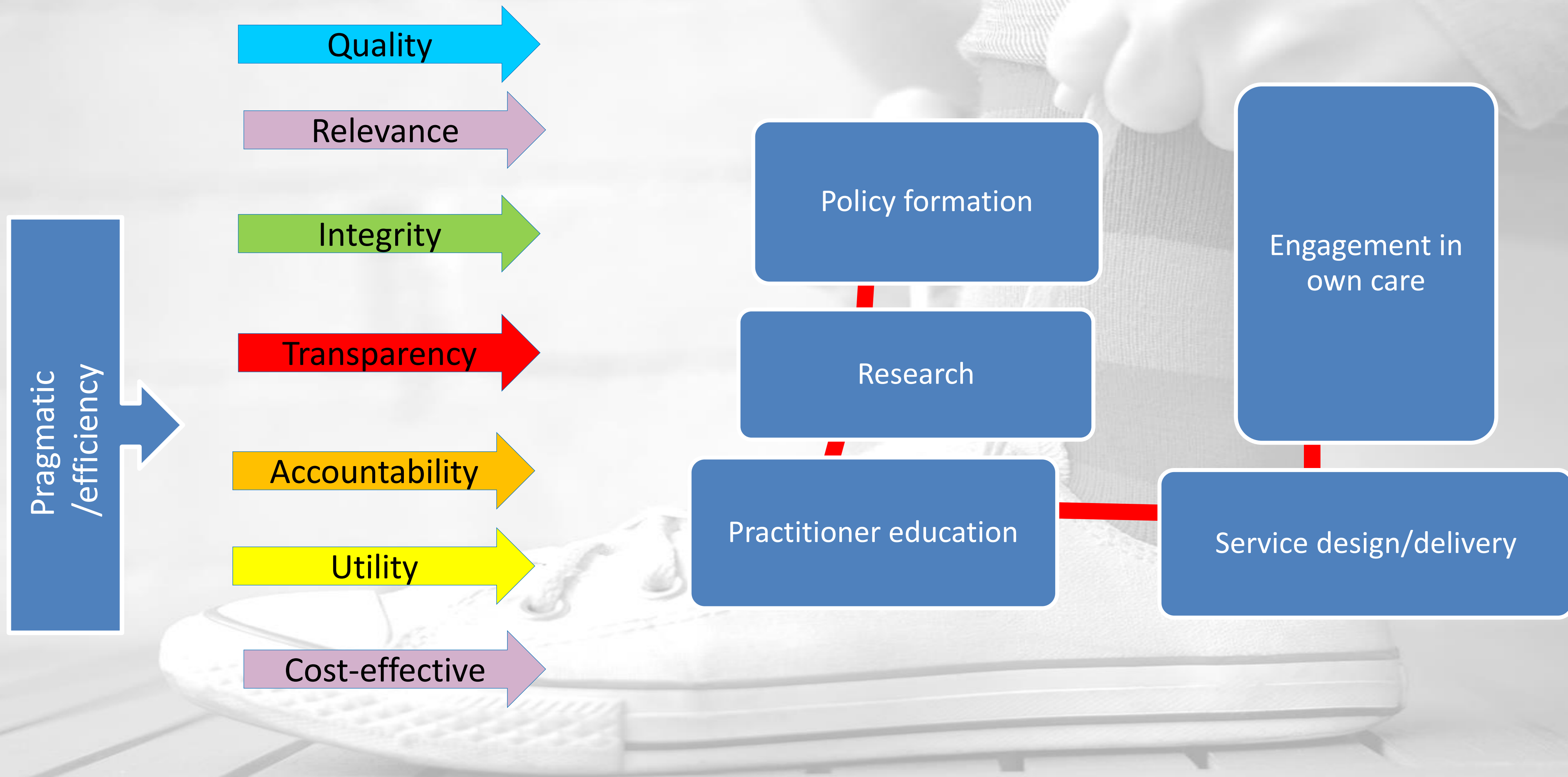




Drive reflected in publication



Efficiency/pragmatic: The person who wears the shoes knows where they pinch



Plethora of definitions

‘Co-production refers to **collaborative** and egalitarian relationships in which users are involved in **co-designing**, co-delivering, co-managing, and co-evaluating public services (Bovaird, 2007)

Co-production means **delivering services in an equal and reciprocal relationship** between professionals, people using services, their families and their neighbours’ (Boyle and Harris 2009 p. 11)

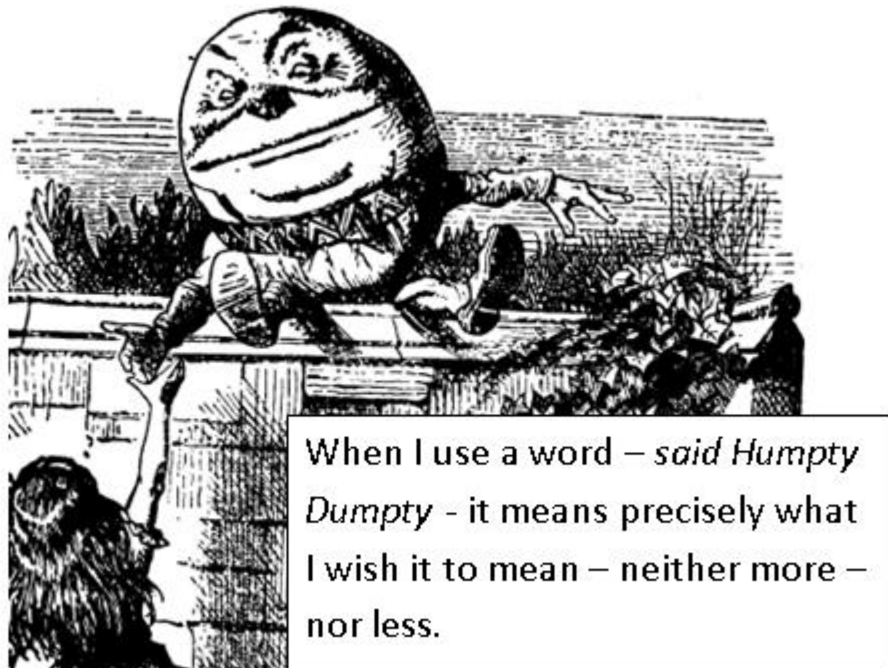
“Coproduction is [...] a way of working whereby [...] people who use services, significant others, family carers and service providers **work together to create** a [...] service which works for them all” (Skills for Health, 2013, p. 1).

‘Co-production recognises that **people who use social care services (and their families) have knowledge** and experience that can be used to help make services better, not only for themselves but for other people who need social care (www.thinklocalactpersonal.org.uk/Browse/ Informationandadvice/CareandSupportJargonBuster/#Co-production)

‘Coproduction is defined as **a collaborative** relationship within either clinical or scientific fields, between two persons with and without experiential expertise that both aim at levelling or, at least, **critically addressing power differentials** (Rose 2000)

A potentially **transformative way of thinking** about power, resources, partnerships, risks and outcomes, not an off-the-shelf model of service provision or a single magic solution’ (Needham and Carr 2009:p1)

Words mean what we want them to mean

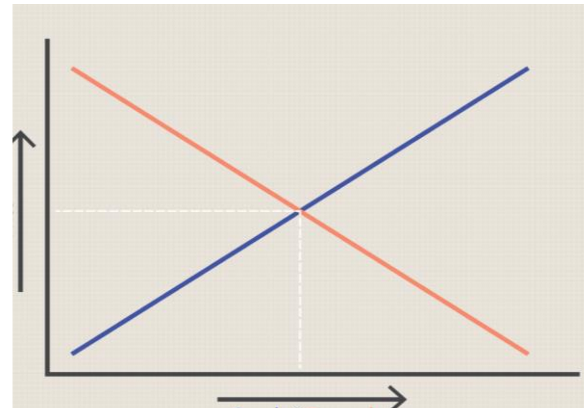


Used interchangeably

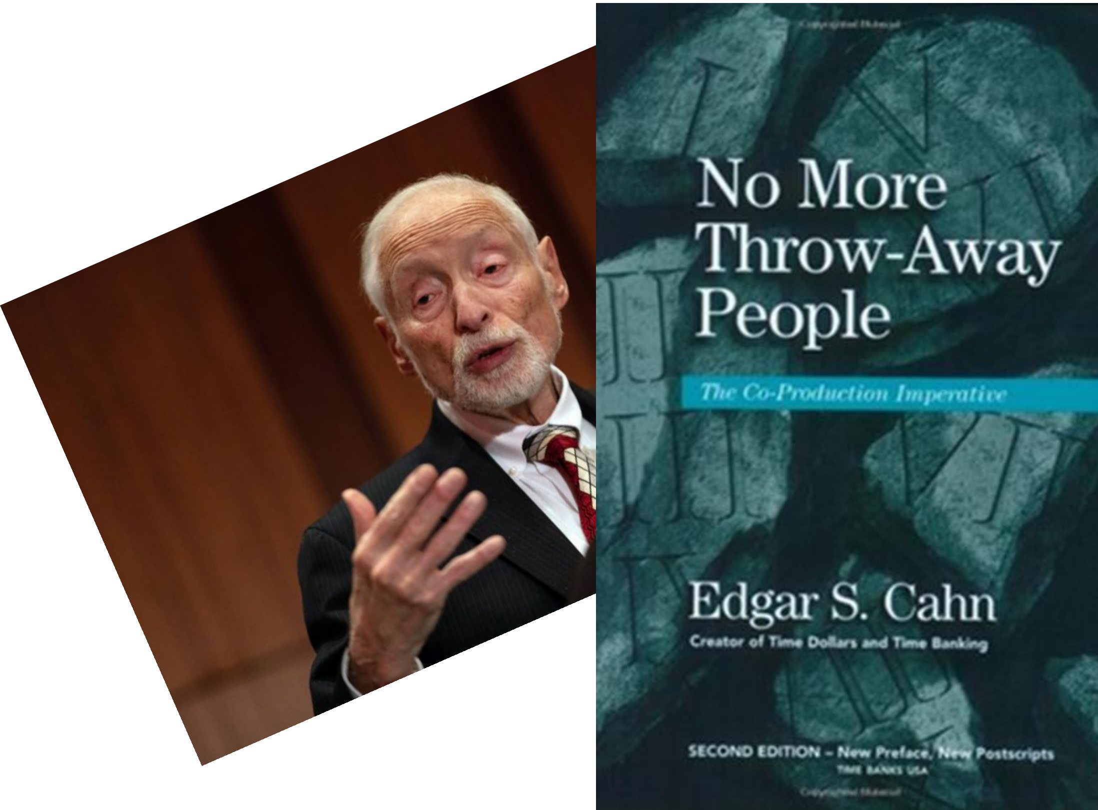
- Consulting
- Involvement
- Partnership
- Engagement
- Co-design
- Patient and Public involvement (PPI)

Return to the roots: First coined

- Professor Elinor Ostrom
- Professor of Political Science



Made popular



- Criticised service for
  - their failure to impact the lives of people
  - created a dependency that convinces people they had nothing worthwhile to offer
  - under mining any system of local support
- ‘Fight against being declared useless’ (Cahn, E 2008, p5)
- Born out of his involvement with **civil rights movement,** which was the prism which supplied ‘**the lens of social justice’**
- ‘Hell-raising is a critical part of co-production’ (Cahn, E 2004: P4)

Co-production: structural transformation and a new social contract

Type of government	Citizen role	Citizens provide …	Government provides …
Old public administration	Subject	Elections and tax resources	Protection of the rights of citizens
New public management	Client	Payments for (collective) services	Value for money
New public governance	Coproducer	Collaborative engagement	Collaborative action

In essence it is a move from the centralised political hierarchical order of state to a more horizontal networking relationship between citizens, families and communities.

ived 4 January 2016
sed 11 April 2016
pted 15 May 2016

Coproduction as a structural transformation of the public sector

Albert Meijer
Utrecht University School of Governance, Utrecht University, Utrecht, The Netherlands

Abstract
Purpose – Coproduction fundamentally changes the roles of citizens and governments. The purpose of this paper is to enhance the theoretical understanding of the transformative changes in the structural order of the public domain that result from the coproduction of public services.
Design/methodology/approach – This paper builds upon both the literature on coproduction of public services, new public governance and on social contracts between citizens and the state to identify the nature, drivers and implications of the transformation. The argument is illustrated with examples from crime control and healthcare.
Findings – The analysis identified an institutional misfit and highlights four key issues that are key to the understanding of the structural transformation of public services: compensation for time and knowledge resources, responses to new forms of (in)equality, risk of conflicts between citizens and re-organizing accountability.
Research limitations/implications – The analysis highlights the need for further research into the implications of coproduction for government legitimacy, transfer of power, financial implications, representativeness and consequences for non-coproducing citizens.
Originality/value – This paper links instrumental debates about the coproduction of public services to fundamental debates about the relations between government and citizens and identifies substantial issues that are raised by this structural transformation in the public domain and that require new responses.
Keywords Coproduction, New public governance, Structural transformation
Paper type Conceptual paper

1. Introduction

The literature on coproduction in the public sector is rapidly expanding and empirical research is being conducted in a broad variety of domains (Bovaird, 2007; Alford, 2009; Pestoff *et al.*, 2013; most recently, Williams *et al.*, 2016). While the theoretical notion of coproduction dates from the 1970s, the idea currently catches momentum and is applied to describe and analyze a wide variety of practices of citizen and stakeholder engagement ranging from housing (Brandsen and Helderman, 2012) to public service delivery (Bovaird, 2007), childcare services (Pestoff, 2006), education (Thomsen and Jakobsen, 2015) and policing (Meijer, 2014). The key point in all these analyses is that traditional distinctions between users/consumers and producers are fading and they are being replaced by cooperative relations.

In spite of the growing attention for coproduction, our understanding of the fundamental nature of coproduction is still limited. Coproduction brings a fundamental re-organization of relations between citizens and government (Bovaird, 2007; Alford, 2009; Pestoff *et al.*, 2013; Radnor *et al.*, 2014) and this transformation challenges important values such as equality, accountability, transparency and proportionality. Many analyses of coproduction, however, are highly interesting but of a rather instrumental nature and fail to tackle the underlying issue of re-arranging the roles of

Co-production: Agree and Disagree

How to get the "P's" right
So that it's not all about the

- Policies
- Procedures
- Pathways
- Paperwork
- Protocols
- Politics

When it should be about the People

Yvonne Newbold, MBE
Founder of Newbold Hope

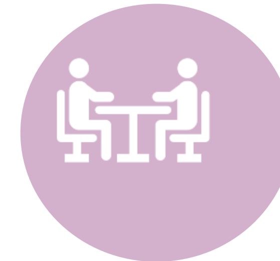
https://www.newboldhope.org/

Core principles of co-production: radically different epistemology

Political agenda Democratisation

Dissolving/ blurring boundaries

Working together in equal and reciprocal relationships



Respecting and valuing different knowledge sources and types of knowledge

Transforming way we think about power

Political agenda: rebalance inequalities and promote democracy

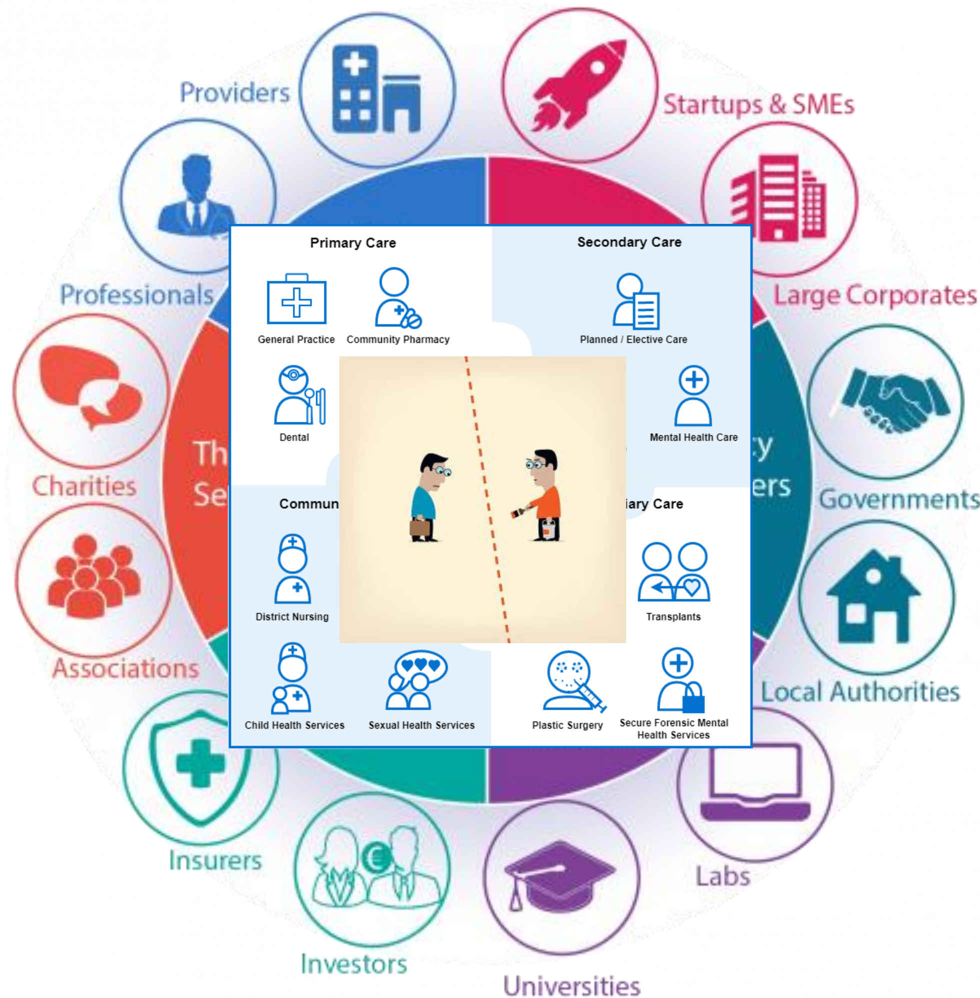
Democratic right of citizen to be involved (Citizen engagement)

Nothing about us without us

Right to have a say in matters that affect or impacts me

Right to influence what is paid for by public money

Dissolving or blurring of boundaries/categories



- Blurring conceptual distinction between participant categories (provider and recipient)
- Blurring structural/organisational distinction between inside and outside systems (boundaries MHS, community)
- Blurring distinctions in terms of location of mental health care

Creating new spaces, places sites for and modes of interaction between individuals (citizens), groups and communities

Working together in equal and reciprocal relationships

Blurring relational boundaries (engagement)

Valuing different sources and types of knowledge:
Disrupting knowledge boundaries

Practitioner

Propositional knowledge that comes from research, theory, clinical experience

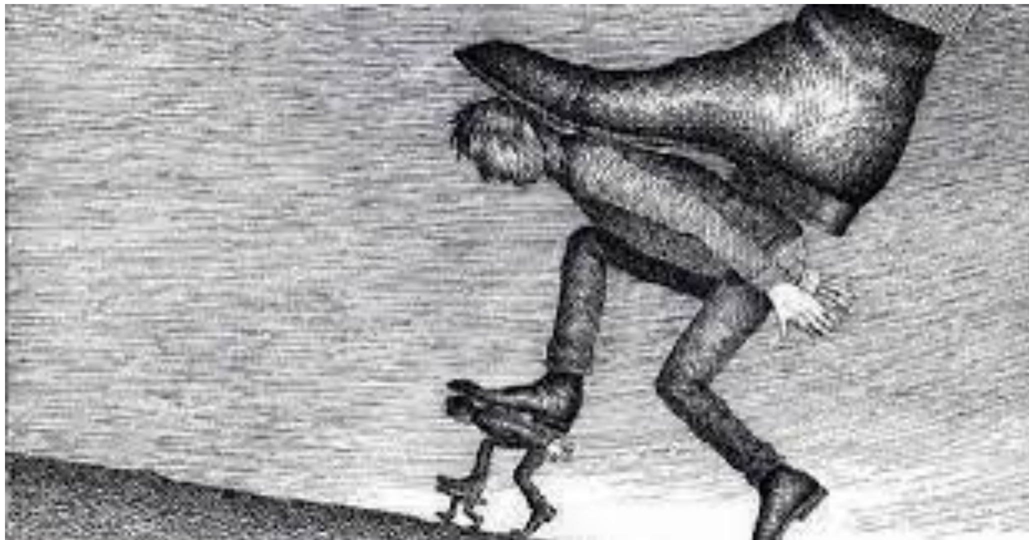
Lived experience

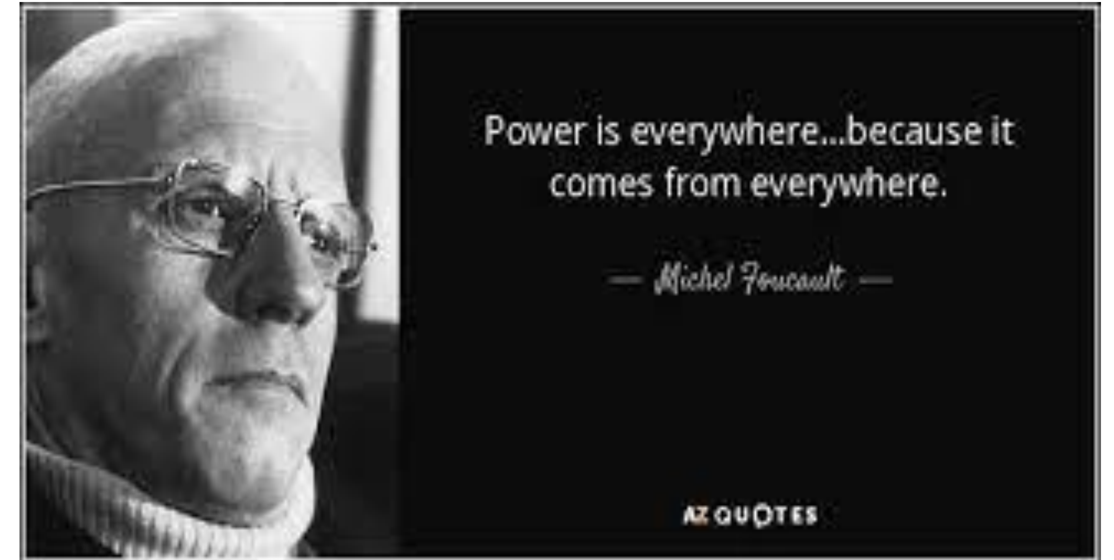
Experiential

'Personal theory'

Process of collaborative sense making

Transformative way of thinking about power



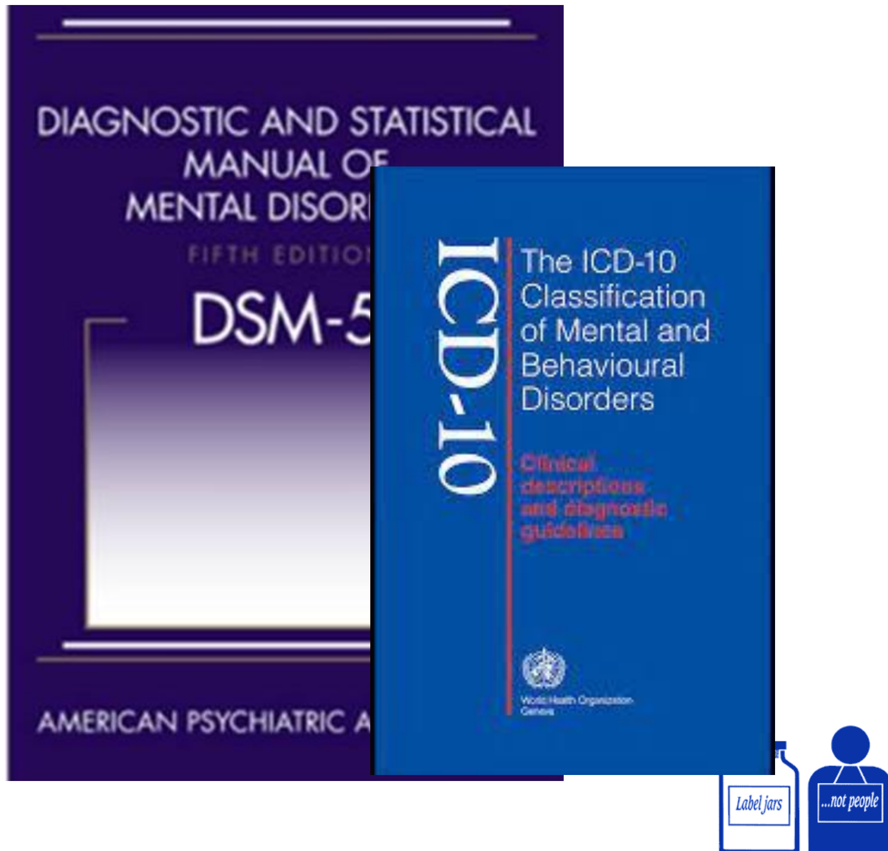


Power is everywhere, diffused and embodied in discourse, knowledge and regimes of truth

(Foucault M, 1966 The Archaeology of Knowledge Routledge)

Transformative way of thinking about power:
Question -how does power operate with the system ?

Ideological power



Power -creation of identities

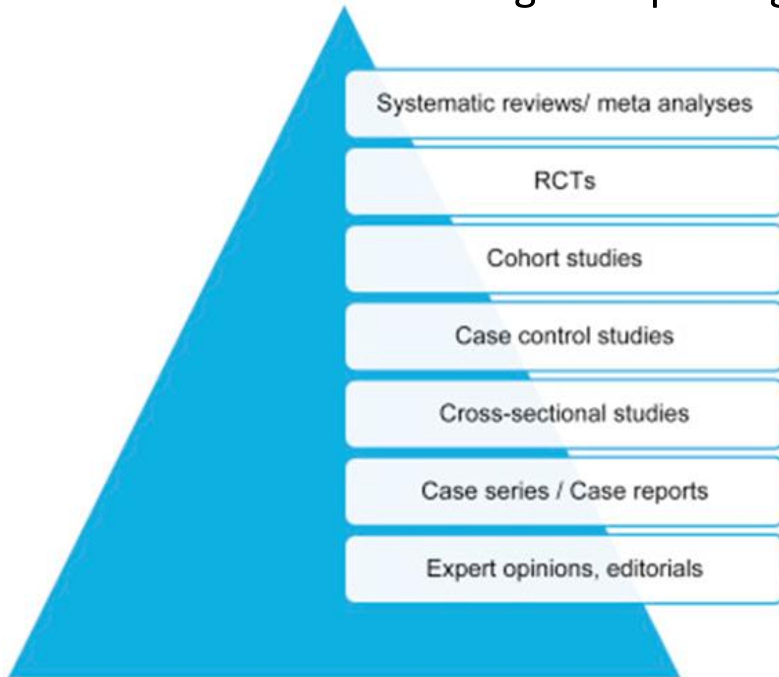
“The single most damaging effect of psychiatric diagnosis is loss of meaning. By divesting people’s experiences of their personal, social, and cultural significance, diagnosis turns **“people with problems” into “patients with illnesses.”** [As a consequence] “stories of trauma, abuse, discrimination, and deprivation are sealed off behind a label as the individual is launched on what is often a lifelong journey of disability, exclusion, and despair”.

Johnstone et al (2018: 31)

‘Passive docile body in need of care’ by expert mental health practitioners (Foucault M, 1966 The Archaeology of Knowledge Routledge)

Transformative way of thinking about power:
Question -how does power operate with the system ?

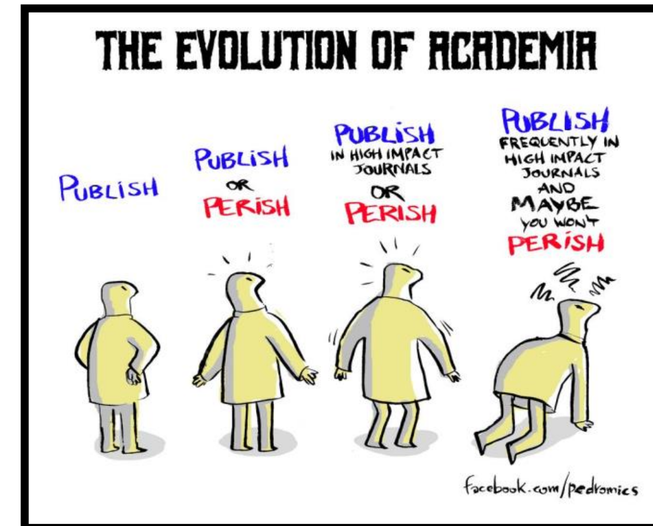
Through the privileging of ways we produce and disseminate knowledge



Traditional hierarchies of knowledge

Elite spaces of academy

Sites of knowledge production



https://walkingscienceshoes.wordpress.com/2020/02/05/publish-or-perish-is-it-that-simple/

Sites of dissemination

Transformative way of thinking about power: Question -how does power operate with the system

Relational boundary power

Person in crisis

Ill person

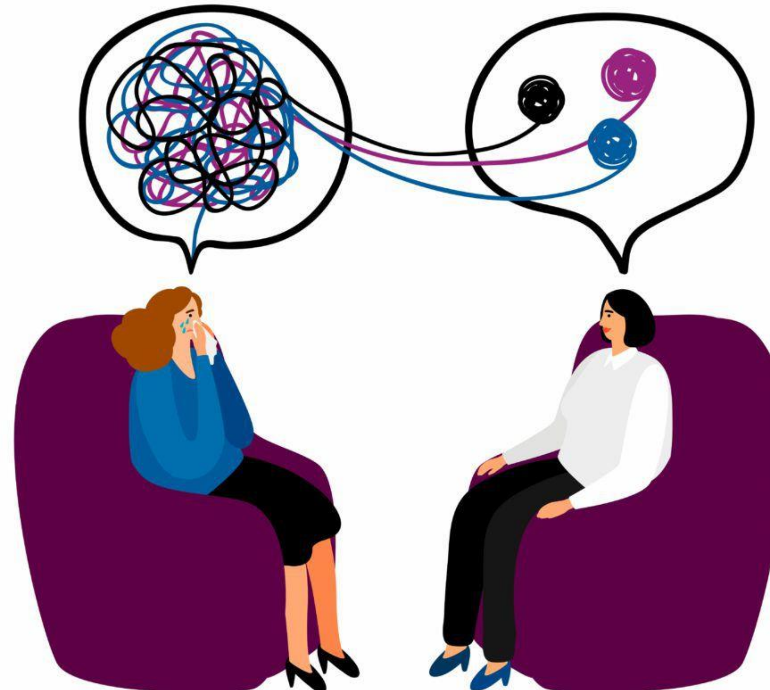
Unstable

Vulnerable user

Mad

Poor decision maker

Self disclosure



https://www.therapyroute.com/article/the-therapeutic-relationship-and-the-process-of-change-an-integrationist-perspective-by-p-renn

Practitioner

Healthy

Stable

Resilient

Competent

Know what is best

‘Professional distance/ impersonal/ do not speak or reveal own crisis experiences’

‘**M**ental health professionals’ own crisis experiences can provide significant added value for clinical and scientific work. However, in many of these co-productive relationships, these experiences are only represented by the participating users. Professional generally hold back with a self-reflexive or open engagement with their own crisis experiences (Rose 2009). **This imbalance raises a number of questions for the field of mental health coproduction: how can a relationship on equal footing develop if one of the participating groups is unwilling to open up?** How are users supposed to succeed in coping with their own stigma if we as mental health professionals are unable to do so ourselves? And what ways are available to deal with issues of power and control, which are so important in collaborative relationships, if one side opens up, but the other does not?’ (von Peter & Schulz 2018)

International Journal of
Mental Health Nursing

International Journal of Mental Health Nursing (2018) 27, 1292–1300 doi: 10.1111/inm.12469

SPECIAL ISSUE

‘I-as-We’ – Powerful boundaries within the field of mental health coproduction

Sebastian von Peter[1] and Gwen Schulz[2]
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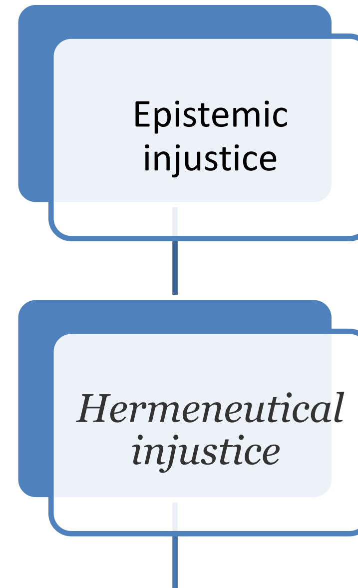
ABSTRACT: *To date, there is little research on personal crisis experiences of mental health professionals. The aim of this study was to explore some of the reasons for why self-disclosure is so difficult and how these difficulties may prevent productive forms of coproduction. These questions are addressed both from a psychiatrist's autoethnographic account and from the perspective of a peer worker who works in various coproductive relationships. It is shown that mental health professionals often revert to an "I-as-we", speaking of themselves as a collective and thereby reifying the boundaries between 'vulnerable users' and 'invulnerable professionals'. Ethnographic examples are given, of how these boundaries are produced by a continuous, often invisible, and powerful category work. It is discussed how the dichotomous logic of these boundaries can cause people on both sides to feel reduced to a representation of a certain species, which can take on an existential dimension. Ways out are identified for mental health professionals to self-reflexively engage with their own crisis experience in coproductive and other relationships.*

KEY WORDS: *collaboration, participation, research, stigma, user-led.*

Transformative way of thinking about power: Question –how does this impact on the person

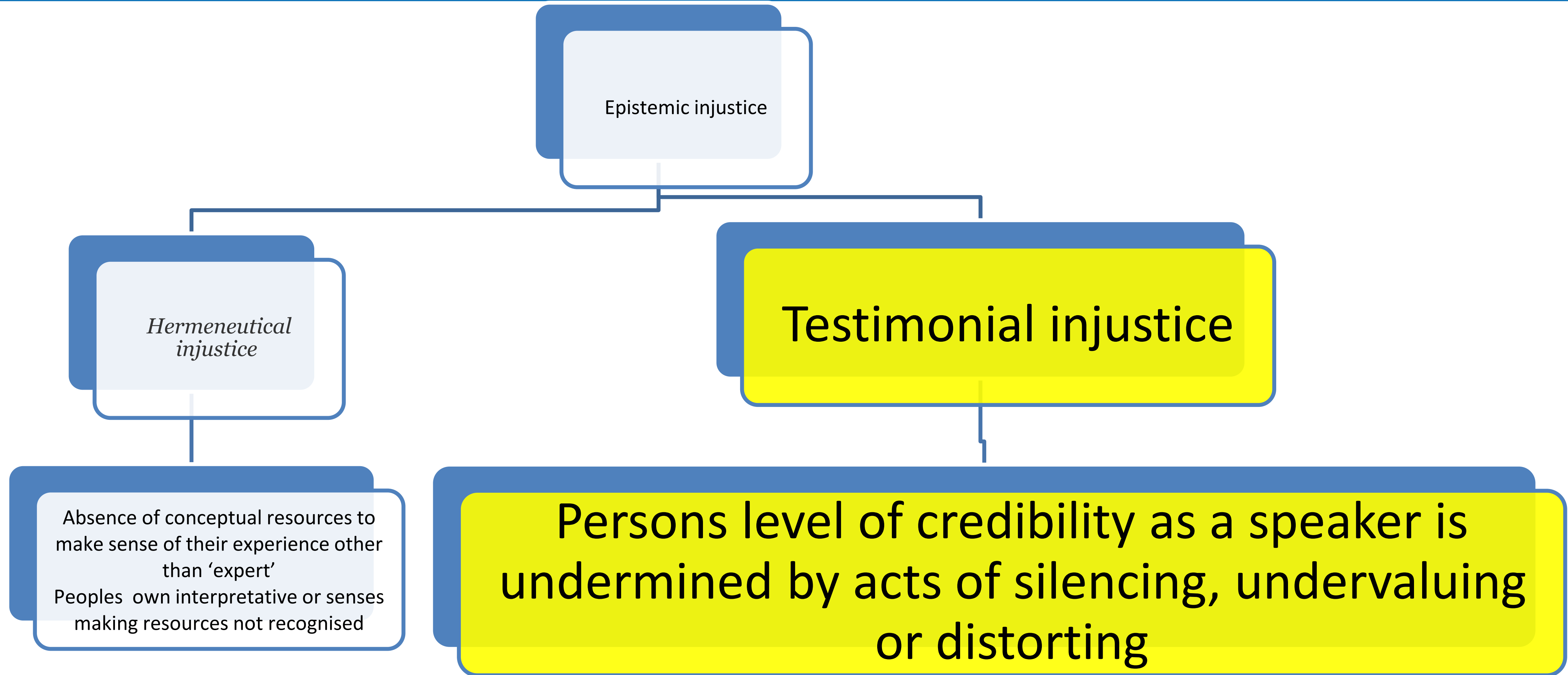


There is an absence of conceptual resources or language to make sense or speak of experience other than 'expert' view

Peoples own interpretative or senses making resources not recognised

(Fricker 2007)

Transformative way of thinking about power: Question –how does this impact



(Fricker 2007)

Look at how we deal with resistance

It is the lightening that reveals the darkness

Power is productive -‘a point of resistance and a starting point for an opposing strategy’… ‘that not said is a hollow that undermines from within all that is said’ (Foucault, M. 1991).

Disagree with or frame diagnosis in a different way:

- Lack of insight
- Psychosis a spiritual crisis

Make decisions we don’t agree with

- Want to taper of medication
- Challenge the biochemical theory

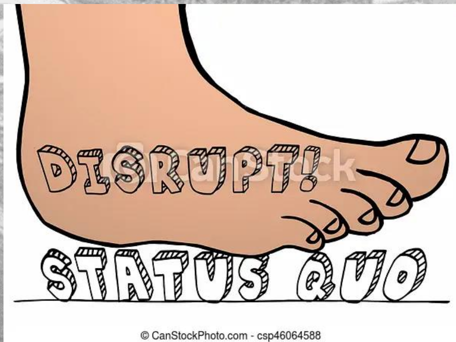
Introduce new ideas within the system

- Peer workers
- Open dialogue
- Power threat meaning framework
  https://www.bps.org.uk/member-networks/division-clinical-psychology/power-threat-meaning-framework

The vision: how far have we travelled ?

Paradigm shift

Co-produciton "a new area of negotiation of meaning and representation"



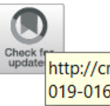
Some great achievement

- Recovery colleges
- Wellness café
- Hearing voices movement
- Open dialogue
- Trialogue meetings
- Mental health festivals
- Peer support services

Brooks et al. Research Involvement and Engagement (2019) 5:25
https://doi.org/10.1186/s40900-019-0161-3
Research Involvement and Engagement

COMMENTARY Open Access

Evaluating the acceptability of a co-produced and co-delivered mental health ...ement festival: Mental Health ...rta, Indonesia



https://doi.org/10.1080/09638237.2022.2140788

REVIEW ARTICLE OPEN ACCESS

Evaluating recovery colleges: a co-created scoping review

Elizabeth Lin[a], Holly Harris[b], Georgia Black[a], Gail Bellissimo[a], Anna Di Giandomenico[c], Terri Rodak[a], Kenya A. Costa-Dookhan[d], Rowen Shier[a], Jordana Rovet[a], Sam Gruszecki[a] and Sophie Soklaridis[a]

[a]Department of Education, Centre for Addiction and Mental Health, Toronto, Canada; [b]Ontario Shores Centre for Mental Health Sciences, Whitby, Canada; [c]SPOR Patient Partner/DAC Patient with Lived Experience, Toronto, Canada; [d]Temerty Faculty of Medicine, University of Toronto, Toronto, Canada

Introduction

frontiers in Psychiatry ORIGINAL RESEARCH published: 21 April 2021

Emerging Processes Within Peer-Support Hearing Voices Groups: A Qualitative Study in the Dutch Context

frontiers in Psychology PERSPECTIVE published: 20 December 2021 doi: 10.3389/fpsyg.2021.744681

Trialogue Meetings: Engaging Citizens and Fostering Communities of Wellbeing Through Collective Dialogue

Liam Mac Gabhann[1]* and Simon Dunne[2]

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Community-based participatory approaches are widely recognized as valuable methods for improving mental health and well-being by enabling a greater sense of liberty among participants, through the development of equitable policies and practices, which accommodate a range of diverse perspectives. One such approach, "Trialogue Meetings," has been found to encourage disclosure and dialogue surrounding mental health, facilitate the growth and development of communities in relation to people's experience of mental health difficulties, service provider and community response. Emerging in the 1990s because of perceived and felt inequitable relations between people with lived experience of mental health difficulties, family members of people with mental health difficulties and professionals providing mental health service provision. This approach has been shown to successfully reduce stigma and discrimination and improve relations between stakeholders in community and mental health care settings. Trialogue Meetings incorporate Open Dialogue methods to allow multiple stakeholder groups to participate in conversations around a given topic and enable the creation of a common language and mutual understanding. Trialogue Meetings have added benefits of allowing individuals to express themselves better, gain a sense of relationality and community with others and address predetermined power hierarchies with prescribed responses to people's experiences. In this perspective, we present an outline for Trialogue Meetings as a medium for enhancing wellbeing, providing a transformative empowering process for deliberate discursive practice and engaging citizens through sustained collective dialogue.

Keywords: open dialogue, trialogues, wellbeing, participation, citizenship, Trialogue Meetings

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*Correspondence: Liam Mac Gabhann liam.macgabhann@dcu.ie
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Evidence: Recovery colleges

Table 2 Contribution of studies to themes

Study	A shift in power	Being connected	Personal growth	Adopting the role of a student	Managing expectations
Cameron *et al.* (2018)	X	X	X	X	–
Dunn *et al.* (2016)	–	X	–	X	X
Ebrahim *et al.* (2018)	X	X	X	X	–
Harper and McKeown (2018)	X	X	X	X	X
Kay and Edgley (2019)	X	X	X	X	–
Meddings *et al.* (2014)	X	X	X	X	X
Newman-Taylor *et al.* (2016)	–	X	X	–	–
Stevens *et al.* (2018)	X	X	X	X	–
Thompson *et al.* (2021)	X	X	X	–	–
Wilson *et al.* (2019)	X	X	X	X	X
Windsor *et al.* (2017)	X	X	X	X	–
Zabel *et al.* (2016)	X	X	X	X	X

Conclusion

Co-production is functioning encouragingly within the Recovery Colleges studied. This is especially true in the context of **sharing power, valuing lived experience, and changing practitioner attitudes**. They are springboard to opportunities; opening doors, increased self-awareness and understanding increased confidence and worth, empowerment and control

What is the impact of recovery colleges on students? A thematic synthesis of qualitative evidence

Ruby Whish, Catherine Huckle and Oliver Mason

Recovery colleges: long-term impact and mechanisms of change

Holly Thompson, Laura Simonds, Sylvie Barr and Sara Meddings

https://doi.org/10.1080/09638237.2022.2140788

REVIEW ARTICLE

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Evaluating recovery colleges: a co-created scoping review

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[a]Department of Education, Centre for Addiction and Mental Health, Toronto, Canada; [b]Ontario Shores Centre for Mental Health Sciences, Whitby, Canada; [c]SPOR Patient Partner/DAC Patient with Lived Experience, Toronto, Canada; [d]Temerty Faculty of Medicine, University of Toronto, Toronto, Canada

ABSTRACT

Background: Recovery Colleges (RCs) are education-based centres providing information, networking, and skills development for managing mental health, well-being, and daily living. A central principle is co-creation involving people with lived experience of mental health/illness and/or addictions (MHA). Identified gaps are RCs evaluations and information about whether such evaluations are co-created.

Aims: We describe a co-created scoping review of how RCs are evaluated in the published and grey literature. Also assessed were: the frameworks, designs, and analyses used; the themes/outcomes reported; the trustworthiness of the evidence; and whether the evaluations are co-created.

Methods: We followed Arksey and O'Malley's methodology with one important modification: "Consultation" was re-conceptualised as "co-creator engagement" and was the first, foundational step rather than the last, optional one.

Results: Seventy-nine percent of the 43 included evaluations were peer-reviewed, 21% grey literature. These evaluations represented 33 RCs located in the UK (58%), Australia (15%), Canada (9%), Ireland (9%), the USA (6%), and Italy (3%).

Conclusion: Our findings depict a developing field that is exploring a mix of evaluative approaches. However, few evaluations appeared to be co-created. Although most studies referenced co-design/co-production, few described how much or how meaningfully people with lived experience were involved in the evaluation.

ARTICLE HISTORY
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KEYWORDS
Recovery college; evaluation; scoping review; co-creation

Recovery Colleges

- Changes within the colleges boundaries
  - relational boundaries (provider and recipient)
  - knowledge boundaries – lived experience
- Challenge to ideological power (diagnosis)
  - people enabled to make sense of their stress using an array of understandings and have power to author own story

Recovery colleges and the ethos of Recovery colleges have **little impact on wider mental health services**

The Vision: how far have we travelled within the system

Paradigm shift
Disruption

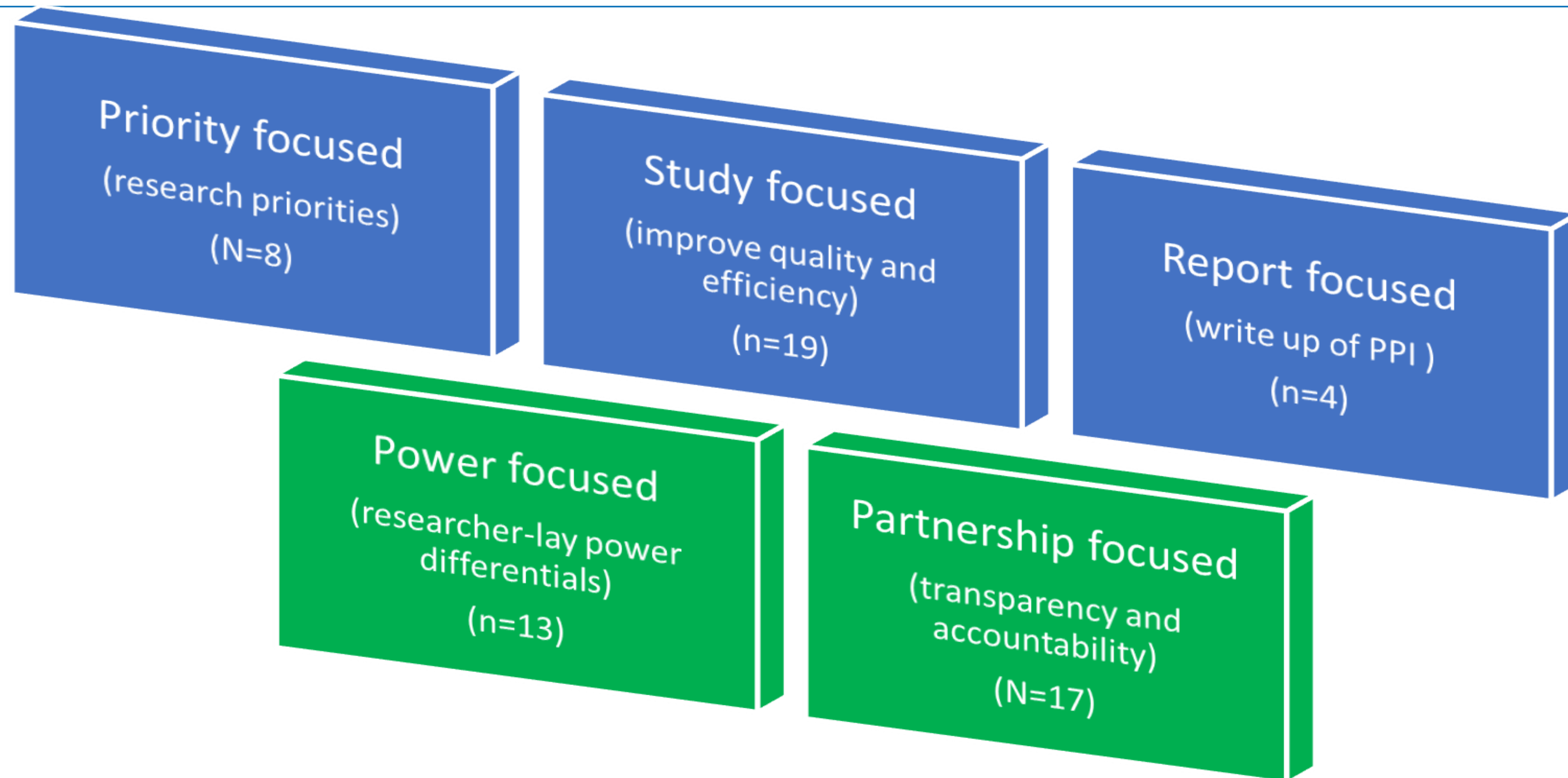
Meta level
Research/knowledge production

Macro level
Informing policy

Meso level
Designing/delivering/managing service
Education of practitioners

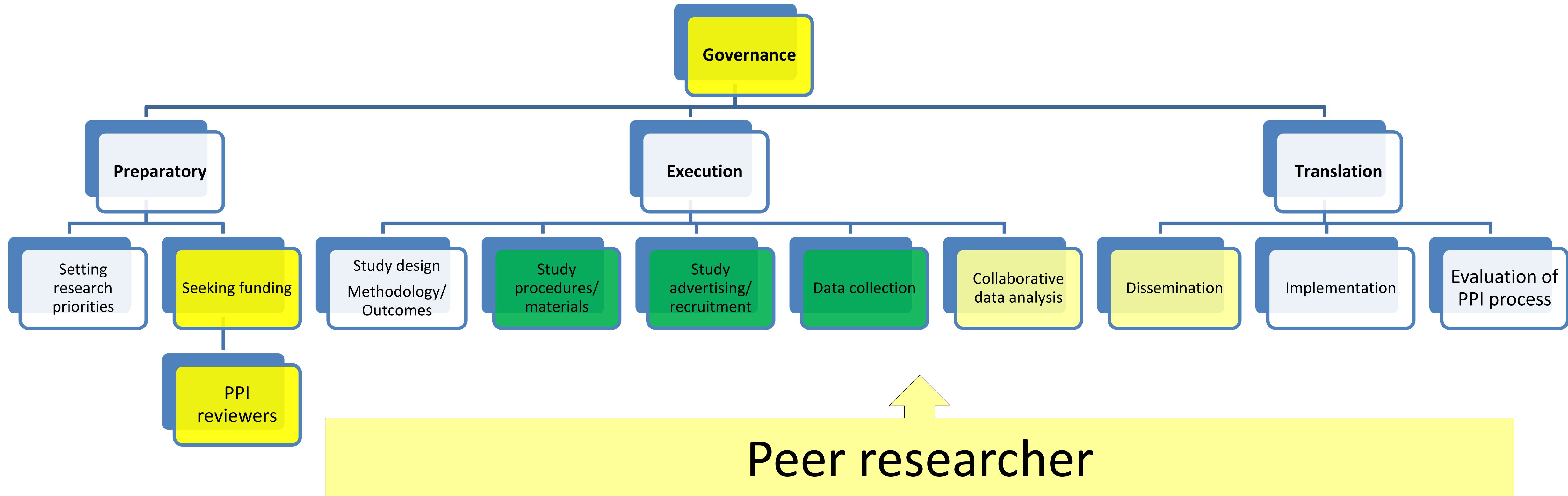
Micro level
Individual level -own care

Meta level research: typology of framework for supporting co-production



Greenhalgh T, Hinton L, Finlay T, et al. Frameworks for supporting patient and public involvement in research: Systematic review and co-design pilot. Health Expect. 2019;22:785–801. https://doi.org/10.1111/hex.12888

Research: reality of involvement

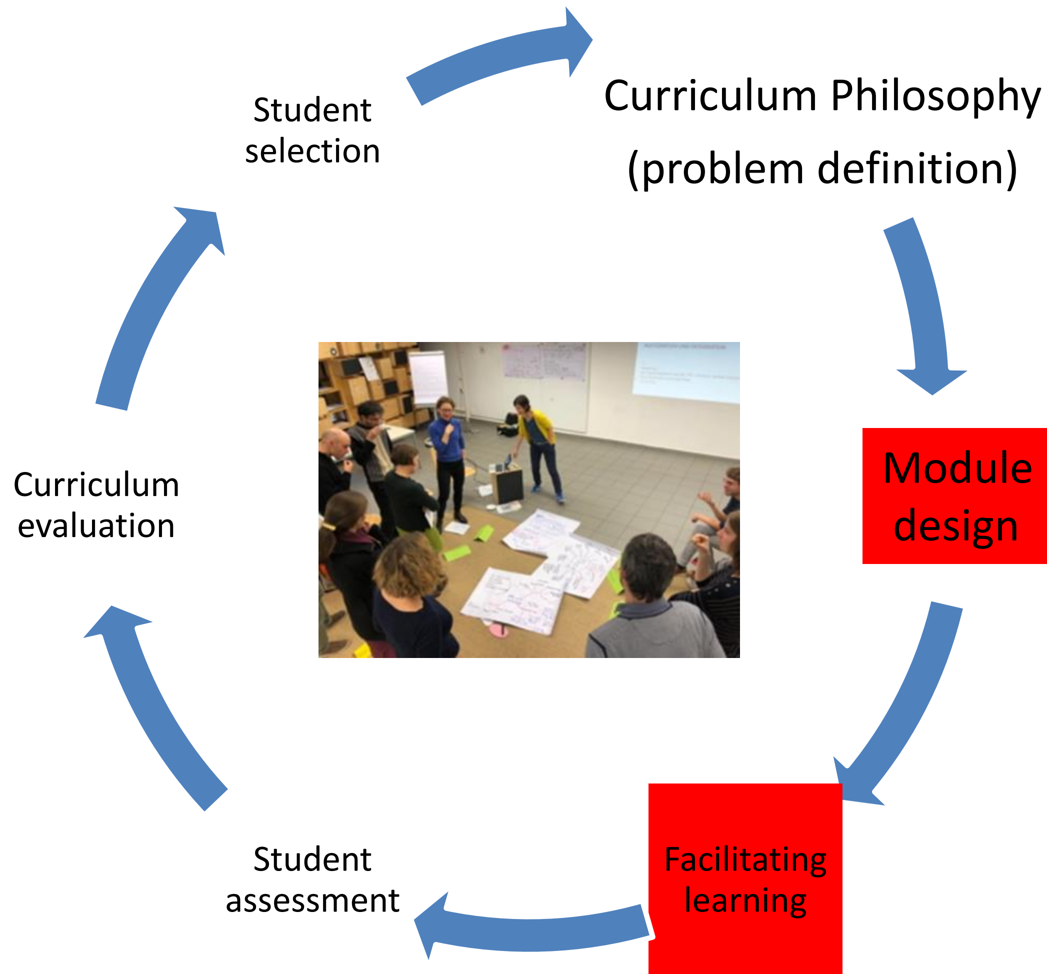


Stanley et al (2013) Service users as collaborators in mental health research: less stick, more carrot Psychol Med. 43(6): 1121–1125
Sangill, C., Buus, N., Hybholt, L., & Berring, L. L. (2019). Service user's actual involvement in mental health research practices: A scoping review. International Journal of Mental Health Nursing, 28(4), 798-815. https://doi.org/10.1111/inm.12
Smith, H, Budworth L, Grindey, C et al (2022) Co-production practice and future research priorities in the UK; a scoping review Health Research Policy and Systems 20:36 https://health-policy-systems.biomedcentral.com/articles/10.1186/s12961-022-00838-x

Macro level -Policy

- Few policies are co-produced
- Co-production translated into language of advise, consultation involvement
- Political aspirations muted or lost in the manner in which mental distress is framed and interventions proposed

Meso level: Pedagogy of practitioner education



Advances in Health Sciences Education
https://doi.org/10.1007/s10459-022-10157-z

“Come and share your story and make everyone cry”: complicating service user educator storytelling in mental health professional education

Stephanie LeBlanc-Omstead[1] · Elizabeth Anne Kinsella[1,2,3]

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Abstract

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DOI: 10.1111/jpm.12870
LIVED EXPERIENCE NARRATIVE
WILEY

Holding Hope: Co-producing eating disorders education that integrates the lived experience voice to inform best practice

Steve Wise[4,5] | Shannon Calvert[6,7]

Accessible Summary

What is known on the subject?

- Eating Disorder (ED) education is predominating taught through a DSM-V diagnostic criteria and clinically focused lens devoid of lived experience expertise.

What the paper adds to existing knowledge?

- Current clinically focused ED education may be shaping health professional misunderstandings of EDs, influencing the therapeutic relationships between health professional and consumer which is key to the recovery process.
- Integrating the lived experience voice through co-produced, humanities-based ED education deepens understandings and honours the complexities of EDs by bringing a much-needed, alternate perspective to health professional learning, practice and research.

What are the implications for mental health nursing?

- Reframing mental health education towards a more strengths-based, trauma-informed and recovery focused lens has the potential to upskill the health workforce in how to hold hope, space and learn to walk the fight with people living and recovering with an ED.

KEYWORDS
eating disorders, education, medical humanities, narratives, patient experience

Australian Occupational Therapy Journal
WILEY

Learning from lived experience: Outcomes associated with students’ involvement in co-designed and co-delivered recovery-oriented practice workshops

Justin Newton Scanlan[1] | Bridget Berry[2] | Karen Wells[2] | Jennie Somerville[3]

[1]Sydney School of Health Sciences, Faculty of Medicine and Health, The University of Sydney, Sydney, New South Wales, Australia
[2]Lived Experience Academic, Sydney School of Health Sciences, Faculty of Medicine and Health, The University of Sydney, Sydney, New South Wales, Australia
[3]Lived Experience Educator, Sydney School of Health Sciences, Faculty of

Abstract

Introduction: Learning from individuals with lived experience is considered an important element of developing recovery-oriented practice capabilities in mental health contexts. Additionally, service user involvement in the education of occupational therapy students is a requirement in accreditation standards. Despite this, many barriers to meaningful inclusion of Lived Experience Educators have previously been identified.

Method: This study evaluated the outcomes achieved by students who were

Meso level of service provision: co-produced interventions

Some examples

- co-produced psychoeducation
- co-facilitated education

Challenge

- Embedding within system
- Challenging biomedical understandings

Irish Journal of Psychological Medicine, page 1 of 10. © College of Psychiatrists of Ireland 2019
doi:10.1017/ipm.2019.32

ORIGINAL RESEARCH

Evaluation of a co-facilitated information and learning programme for service users: the EOLAS programme

, N. Cusack[4] and P. Gibbons[4]

ation programmes is one way in which service users

nation programme on service users' knowledge, con-
ence of the programme.
changes in knowledge, confidence, advocacy, recov-
-structured interviews with programme participants
eys and twelve individuals consented to interviews.
users' knowledge about mental health issues, confi-
ch emerged from the interviews with participants (n
ess, and a greater sense of hope. In addition, the peer
acilitation engendered equality of participation and
rs and practitioners.
ser and clinician co-facilitated education programme

The CORE study—An adapted mental health experience codesign intervention to improve psychosocial recovery for people with severe mental illness: A stepped wedge cluster randomized-controlled trial

Victoria J. Palmer PhD, BA(Hons)[1,2] | Patty Chondros PhD, Associate Professor[1,2] | John Furler PhD, FRACGP, Professorial Research Fellow[1] | Helen Herrman MD, FRANZCP, Professor[3] | David Pierce MD, Associate Professor[4] | Kali Godbee MPsych[1] | Konstancja Densley MSocSci, MStats[1,2] | Jane M. Gunn PhD, FRACGP, Professor[1,2]

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Department of Health and Human Services, Victoria Government : Mental Illness Research Fund (MIRF: 28) and the Psychiatric Illness and Intellectual Disability Donations Trust Fund (PIIDDTF)

Abstract

Background: Mental health policies outline the need for codesign of services and quality improvement in partnership with service users and staff (and sometimes carers), and yet, evidence of systematic implementation and the impacts on healthcare outcomes is limited.

Objective: The aim of this study was to test whether an adapted mental health experience codesign intervention to improve recovery-orientation of services led to greater psychosocial recovery outcomes for service users.

Design: A stepped wedge cluster randomized-controlled trial was conducted.

Setting and Participants: Four Mental Health Community Support Services providers, 287 people living with severe mental illnesses, 61 carers and 120 staff were recruited across Victoria, Australia.

Main Outcome Measures: The 24-item Revised Recovery Assessment Scale (RAS-R) measured individual psychosocial recovery.

Results: A total of 841 observations were completed with 287 service users. The intention-to-treat analysis found RAS-R scores to be similar between the intervention (mean = 84.7, SD= 15.6) and control (mean = 86.5, SD= 15.3) phases; the adjusted estimated difference in the mean RAS-R score was −1.70 (95% confidence interval: −3.81 to 0.40; $p = .11$).

Discussion: This first trial of an adapted mental health experience codesign intervention for psychosocial recovery outcomes found no difference between the intervention and control arms.

Meso level of service provision: peer workers

- Positive effect on
  - empowerment, hope and self-reported recovery
  - working alliance between service users and mental health workers, and social network support.

- Many barriers to integration
  - oganisational culture, practitioner knowledge and attitudes
  - burn out or break out

- Addition of peer workers within services and teams **in isolation of changes** to other parts of the service culture **is inadequate** to foster recovery-oriented services

White et al. BMC Psychiatry (2020) 20:534
https://doi.org/10.1186/s12888-020-02923-3
BMC Psychiatry
RESEARCH ARTICLE Open Access

The effectiveness of one-to
support in mental health se
systematic review and met

Sarah White[1], Rhiannon Foster[1], Jacqueline Marks[1], Rosaleen M

RESEARCH ARTICLE

A systematic review and meta
randomised controlled trials of
people with severe mental illn

Brynmor Lloyd-Evans[1*], Evan Mayo-Wilson[2], Bronwyn Harrison[2], Hanna
Sonia Johnson[1] and Tim Kendall[4]

Abstract
Background
illness.
Method: A s
PsycINFO, ar
non-resident
separately as
were perforr
Results: Eigl
programmes
variation bet
reported; the
there was lit
symptoms o
effects on m
was not con
Conclusions
current trials
positive find
recommend
support proc

Administration and Policy in Mental Health and Mental Health Services Research (2022) 49:596–612
https://doi.org/10.1007/s10488-021-01186-8
ORIGINAL ARTICLE

A Narrative Review of Factors Influencing Peer Support Role Implementation in Mental Health Systems: Implications for Research, Policy and Practice

Elmira Mirbahaeddin[1] · Samia Chreim[1]

Social Psychiatry and Psychiatric Epidemiology (2020) 55:285–29
https://doi.org/10.1007/s00127-019-01739-1
ORIGINAL PAPER

A systematic review of influences on implementation of peer support work for adults with mental health problems

Nashwa Ibrahim[1,2] · Dean Thompson[1] · Rebecca Nixdorf[3] · Jasmine Kalha[4] · Richard Mpango[5] · Galia Moran[6] · Annabel Mueller-Stierlin[7] · Grace Ryan[8] · Candelaria Mahlke[8] · Donat Shamba[9] · Bernd Puschner[5] · Julie Repper[10] · Mike Slade[1]

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Abstract
Purpose The evidence base for peer support work in mental health is established, yet implementation remains a challenge. The aim of this systematic review was to identify influences which facilitate or are barriers to implementation of mental health peer support work.
Methods Data sources comprised online databases ($n = 11$), journal table of contents ($n = 2$), conference proceedings ($n = 18$), peer support websites ($n = 2$), expert consultation ($n = 38$) and forward and backward citation tracking. Publications were included if they reported on implementation facilitators or barriers for formal face-to-face peer support work with adults with a mental health problem, and were available in English, French, German, Hebrew, Luganda, Spanish or Swahili. Data were analysed using narrative synthesis. A six-site international survey [Germany (2 sites), India, Israel, Tanzania,

Microsystem- interpersonal level of care

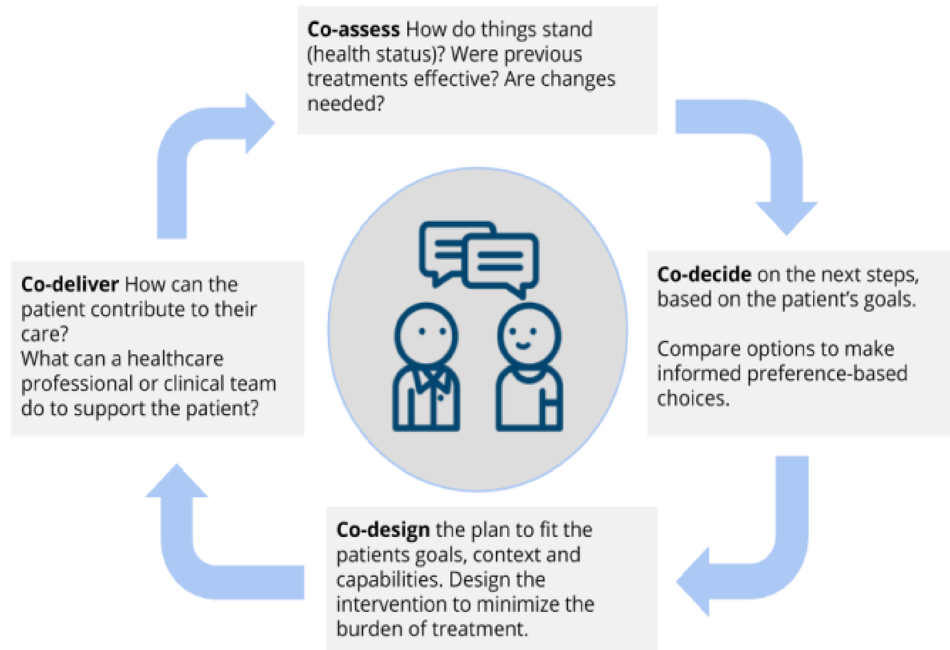

Figure 1 Coproduction cycle: cooperation for optimal care.

VIEWPOINT

Coproduction: when users define quality

Glyn Elwyn,[1] Eugene Nelson,[1] Andreas Hager,[2] Amy Price[3]

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INTRODUCTION

If the core aim of a healthcare system is to minimise both illness and treatment burden while reducing the costs of care delivery, then we must accept, however reluctantly, that our efforts are largely failing.

Life expectancy in highly developed countries is declining for the first time in decades. Long-term conditions and obesity are replacing infectious diseases as the most prominent health problems in developing nations. Meanwhile, average per capita healthcare expenditures are increasing despite efforts to restrain them. For example, in the USA, the average per capita healthcare expenditures are approaching $10 000 a year and consuming over 18% of its gross domestic product. Innovations in biomedicine, information technology and healthcare delivery systems may help address some of the challenges, but instead of containing costs these innovations tend to expand services.

There are indications that interest in a concept called coproduction in healthcare is increasing. The core thesis is that by leveraging professional and end user collaboration, patients can be supported to contribute more to the management of their own conditions. This is especially true when dealing with long-term conditions, where supporting the person to learn how best to reduce the burden of both illness and treatment is an undisputed good. The goal is to cocreate value. Ostrom,[1] based on her seminal work as an

to as 'facilitated networks'. Facilitated networks offer a powerful strategy that has been adopted by many organisations to increase access, and to improve quality while lowering costs. For example, Uber and Lyft, Airbnb, eBay, and Wikipedia have rapidly changed how we travel in cities, find accommodation, sell used goods and search for information by successfully using facilitated networks to connect resources.

Healthcare service is of course more complex than a travel agency, bank or a ride share service. Health is a long-term commitment that requires specialised and nuanced expertise of clinicians and patients. The context and complexity are constantly changing: attention to short-term problems at age 20 is vastly different from dealing with dementia or with chronic obstructive pulmonary disease diagnosis in a man of 80. As options for managing illness expand, so does the role of coproduction, both at individual and population levels. The use of standardised incentives may conflict with the agreements achieved by collaboration. For example, my provider and I might decide not-so-tight control of my cholesterol is best given the low-risk factors and significant side effects. A clinician might be working in a pay-for-performance environment where statins prescribing is rewarded. Patient-centred models, such as the chronic care model,[3] patient engagement,[4] evidence-based self-management[5] and shared decision making,[6] may need to address these challenges if they are to

to note that

Co-production implies equality not just in the sense of persons but at the level of how knowledge itself is valued"

Microsystem- interpersonal level of care

- Nurses have positive attitude and indicated that service users should participate in service delivery and care (espoused theory)
- ***Nurses take control of decisions when they perceived that service users' decisions were detrimental (THEORY IN USE)***
- Litmus test what service users say
  - Many service users still experience exclusion from decision making
  - If involved it is often tokenistic and service user preferences were typically only incorporated when they accorded with health professionals' views about appropriate treatment.
  - Reauthor peoples stories within the diagnostic framework , listening for symptoms -' symptom spotters'

'

Stomski and Morrison *Int J Ment Health Syst* (2017) 11:67
DOI 10.1186/s13033-017-0174-y

International Journal of Mental Health Systems

REVIEW Open Access

Participation in mental healthcare: a qualitati

Norman J. Stomski*

Abstract
Background: Facil
vice delivery is an ir
service users contin
research about part
pation in mental he
Methods: Electron
qualitative studies,
Appraisal Skills Prog
used to identify sim
Results: The synth
tate service user pa
knowledge; lacking
Conclusions: This
aspiration, which ge
the delivery of men
advocacy groups co
mental health servi

BJPsych The British Journal of Psychiatry (2019)
214, 329–338. doi: 10.1192/bjp.2019.22

Review

Experiences of in-patient mental health services: systematic review

Sophie Staniszewska, Carole Mockford, Greg Chadburn, Sarah-Jane Fenton, Kamaldeep Bhui, Michael Larkin, Elizabeth Newton, David Crepaz-Keay, Frances Griffiths and Scott Weich

Background
In-patients in crisis report poor experiences of mental healthcare not conducive to recovery. Concerns include coercion by staff, fear of assault from other patients, lack of therapeutic opportunities and limited support. There is little high-quality evidence on what is important to patients to inform recovery-focused care.

Aims
To conduct a systematic review of published literature, identifying key themes for improving experiences of in-patient mental healthcare.

Method
A systematic search of online databases (MEDLINE, PsycINFO and CINAHL) for primary research published between January 2000 and January 2016. All study designs from all countries were eligible. A qualitative analysis was undertaken and study quality was appraised. A patient and public reference group contributed to the review.

Results
Studies (72) from 16 countries found four dimensions were consistently related to significantly influencing in-patients' experiences of crisis and recovery-focused care: the importance of high-quality relationships; averting negative experiences of coercion; a healthy, safe and enabling physical and social environment; and authentic experiences of patient-centred care. Critical elements for patients were trust, respect, safe wards, information and explanation about clinical decisions, therapeutic activities, and family inclusion in care.

Conclusions
A number of experiences hinder recovery-focused care and must be addressed with the involvement of staff to provide high-quality in-patient services. Future evaluations of service quality and development of practice guidance should embed these four dimensions.

Declaration of interest
K.B. is editor of *British Journal of Psychiatry* and leads a national programme (Synergi Collaborative Centre) on patient experiences driving change in services and inequalities.

Keywords
In-patient; mental health services; experiences; systematic review.

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Patient experience is a vital source of evidence that can drive the provision of high-quality health services.[1,2] Mental health in-patients report a range of experiences including fear of assault, concerns regarding coercion, limited recovery-focused support and lack of therapeutic activities.[3–8] A triennial review of mental health services in England by the Care Quality Commission (2017)[9] highlighted several serious concerns about in-patient care, including wards located in older buildings not designed to meet the needs of acute patients, unsafe staffing levels and overly restrictive care in wards far from patients' homes and families.

The National Health Service (NHS) is under pressure to deliver

Method

The review was divided into a scoping review to ascertain the nature and size of the evidence base, and the main systematic review.

Protocol and registration

The EURIPIDES (Evaluating the Use of Patient Experience Data to Improve the Quality of Inpatient Mental Health Care) systematic review was registered in 2016 on PROSPERO: CRD42016033556.

Scoping review

What we see:

GAELIC

Athletic Association.

Football Rules,

AS

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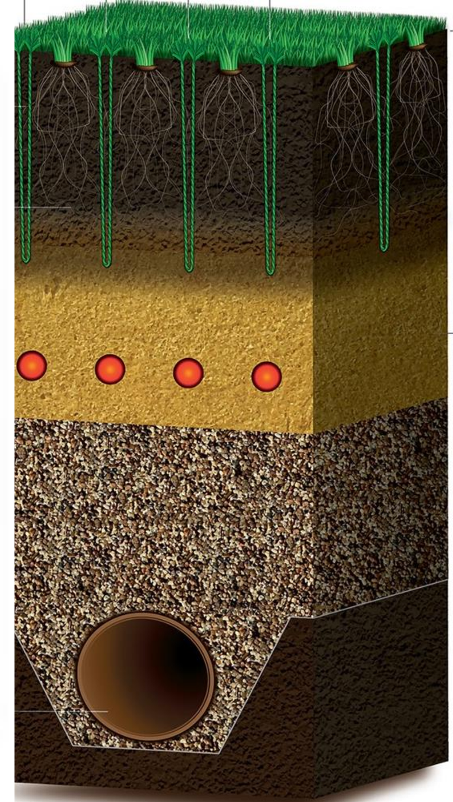
JAN.,



What we see:

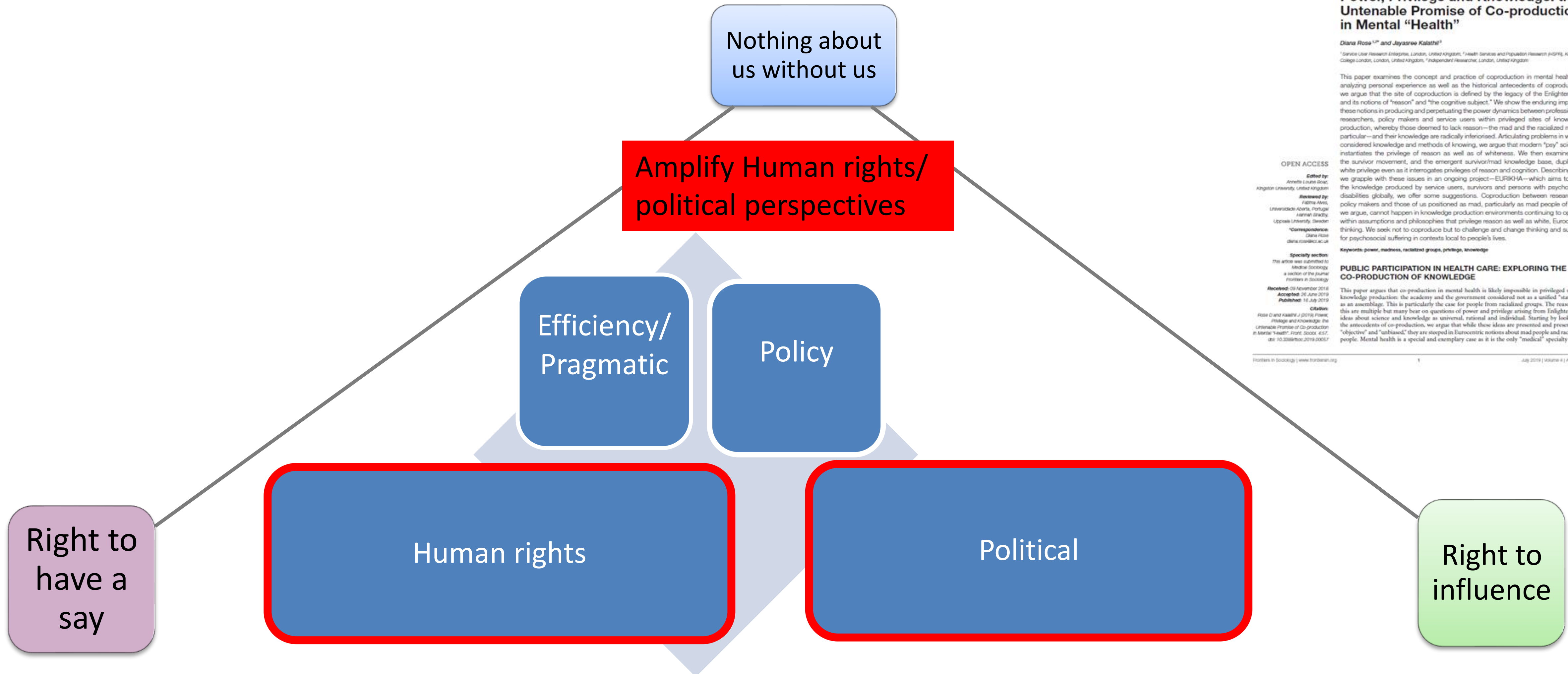
Managerialist/consumerist/market based approach

So is it a dead concept that just created a ripple

Not an off-the-shelf model of service provision or a single magic solution' (Needham and Carr 2009:p1)

- **Is it possible ????????????????**
  - at the micro level of the individual with a legal system that operates rights of detention and a medical system that has power to label
  - within a mental health system that defaults to resistance, co-option or colonisation

No easy solution: some thoughts



frontiers in Sociology
HYPOTHESIS AND THEORY
published: 16 July 2019
doi: 10.3389/fsoc.2019.00057

Power, Privilege and Knowledge: the Untenable Promise of Co-production in Mental "Health"

Diana Rose[1,2]* and Jayasree Kalathil[3]

[1] Service User Research Enterprise, London, United Kingdom, [2] Health Services and Population Research (HSPR), King's College London, London, United Kingdom, [3] Independent Researcher, London, United Kingdom

https:/ 7/full

This paper examines the concept and practice of coproduction in mental health. By analyzing personal experience as well as the historical antecedents of coproduction, we argue that the site of coproduction is defined by the legacy of the Enlightenment and its notions of "reason" and "the cognitive subject." We show the enduring impact of these notions in producing and perpetuating the power dynamics between professionals, researchers, policy makers and service users within privileged sites of knowledge production, whereby those deemed to lack reason—the mad and the racialized mad in particular—and their knowledge are radically inferiorised. Articulating problems in what is considered knowledge and methods of knowing, we argue that modern "psy" sciences instantiates the privilege of reason as well as of whiteness. We then examine how the survivor movement, and the emergent survivor/mad knowledge base, duplicates white privilege even as it interrogates privileges of reason and cognition. Describing how we grapple with these issues in an ongoing project—EURIKHA—which aims to map the knowledge produced by service users, survivors and persons with psychosocial disabilities globally, we offer some suggestions. Coproduction between researchers, policy makers and those of us positioned as mad, particularly as mad people of color, we argue, cannot happen in knowledge production environments continuing to operate within assumptions and philosophies that privilege reason as well as white, Eurocentric thinking. We seek not to coproduce but to challenge and change thinking and support for psychosocial suffering in contexts local to people's lives.

Keywords: power, madness, racialized groups, privilege, knowledge

OPEN ACCESS

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PUBLIC PARTICIPATION IN HEALTH CARE: EXPLORING THE CO-PRODUCTION OF KNOWLEDGE

This paper argues that co-production in mental health is likely impossible in privileged sites of knowledge production: the academy and the government considered not as a unified "state" but as an assemblage. This is particularly the case for people from racialized groups. The reasons for this are multiple but many bear on questions of power and privilege arising from Enlightenment ideas about science and knowledge as universal, rational and individual. Starting by looking at the antecedents of co-production, we argue that while these ideas are presented and preserved as "objective" and "unbiased," they are steeped in Eurocentric notions about mad people and racialized people. Mental health is a special and exemplary case as it is the only "medical" specialty where

Problematise the inside

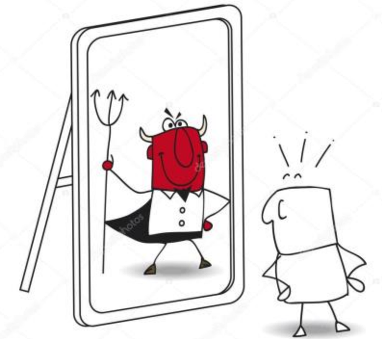
Are we perpetuating injustice

Critical reflexive standpoint that questions the traditional epistemology that underpinned mental health practice, research, education and policy

- Frames distress as illness
- Privileges certain knowledge production and dissemination processes
- Perpetuates epistemic injustice though breaking link between distress and social justice issues

Problematise how inclusion unfolds

- **Who do we co-produce with ??**
  - Mirror images of self- people that thing like us, self-pathologies, concur with the medical model, believe or not believe in medication,
  - Articulate/most able, white, global north view
- **How do we respond to resistance**
  - Institutional, knowledge, discipline and individual practices that silence discount, pathologize, 'strategically selecting', underestimate



- **Question is persons voice being appropriated by**
  - agencies/disciplines to give legitimacy to their decision making process or as a mechanism for researchers to increase access to funding without changing anything
    - as a cover for unpopular decisions or that leave policy decisions that perpetuate inequalities unquestioned

‘Hold our current sources and forms of knowledge about mental distress with tentative fingers’

Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

Co-production in policy, practice research and education: ripples or ravines

Professor Agnes Higgins

Thank You

ahiggins@tcd.ie