# Co-production
## Putting principles into practice in mental health contexts

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# Introduction

Co-production is a way for participants with different expertise to collaboratively work together. The term 'co-production' is frequently used in public service discourse, but has become something of a buzzword lacking robust conceptual or practical foundations; in this resource we explore how co-production goes beyond traditional consumer participation models. In fact, co-production is not a model, rather it is a theory with a set of values and principles. Moving beyond traditional participation models is a challenge to the status quo for many government departments and service-delivery organisations, and even for consumers unaccustomed to having real power.

This resource has been developed to inform and support understanding, planning, and implementing co-production initiatives specifically within the context of Victorian mental health services. There are some unique considerations to be addressed when mental health consumers, clinicians, health service and other agency staff co-produce together to ensure that throughout the process, consumers are positioned as knowledge holders, leaders and people from whom there is much to learn. We know that a diagnosis of mental illness can position people as being 'sick,' 'suffering,' 'irrational' or even 'scary' and, even though we try not to be negatively influenced, such fears and thoughts can impact on how we all work together. Very few people are immune to cultural stereotypes and most mental health workers are more familiar with being in an influential clinical relationship with consumers, rather than a co-producing one. Although there are a number of excellent co-production resources (some of which are presented in this document), there are few that take into account the specific challenges of working co-productively in the mental health context.

This resource seeks to explain what co-production is, how it is important, how it is different to other participatory approaches, and specific considerations for mental health and similar contexts in which extreme power differentials are likely to have been experienced by co-production partners. It offers advice on establishing the culture and mindsets from which co-production can take place. It is a resource that we hope will influence approaches to mental health work, policy development, and consumer participation.

EXTREME POWER DIFFERENTIALS are likely to HAVE BEEN EXPERIENCED BY CO-PRODUCTION PARTNERS

# What is co-production?

Co-production has diverse roots, therefore when people speak of co-production, they may have different understandings of what it is. The term was originally coined by the political economist Eleanor Ostrom in the 1970s (Ostrom & Ostrom, 1978). Later, Edgar Cahn's work on the "core economy" and "Timebanking" laid strong social justice and community-development foundations of co-production (Cahn, 2000) and many of the principles Cahn advocated, such as reciprocity and recognising people as assets, have become core principles in the contemporary co-production literature.

The field of co-design has been an important influence for co-production. Co-design engages end-users in the design of products or services so they will better serve their intended purpose. It is not possible to engage in robust co-production without also engaging in co-design. Planning, designing and producing services with people that have experience of the problem or service, rather than with people that are removed from the problem, means the final solution is more likely to meet the users' needs. Co-production raises the bar for working with consumers, shifting from seeking *involvement or participation* **after** an agenda has already been set, to seeking consumer *leadership* **from the outset** so that consumers are engaged in the initial thinking and priority-setting processes.

A co-production approach sees consumers involved in, or leading, defining the problem, designing and delivering the solution, and evaluating the outcome, either with professionals or independently. Co-production requires longer term engagement from professionals or clinicians, but leads to "profound and sustainable change" (Spencer et al, 2013, p. 7).

Figure 1 displays the typical phases a co-produced initiative will go through. All phases need to be developed collaboratively in co-production including co-planning, co-design, co-delivery and co-evaluation. Each of the phases can stand alone as a collaborative activity, but co-production cannot occur without full collaboration in considering all of these phases.

There has been growing interest in co-production in the past decade, particularly in the UK, in the context of promoting partnerships between governments, services, service users and communities in the commissioning and development of health and community services (Boyle & Thomas, 2009). In service contexts co-production is seen as enabling people's democratic rights to shape the services they use as well as being underpinned by the principle that service users have unique knowledge and skills that are essential to providing a quality service.

Collaborative relationships between individual consumers and professionals (such as health professionals) in a service-delivery context should not be described as co-production. In this context the collaborative process should be referred to as shared or supported decision-making (depending on whether decisions are shared or led by the consumer).
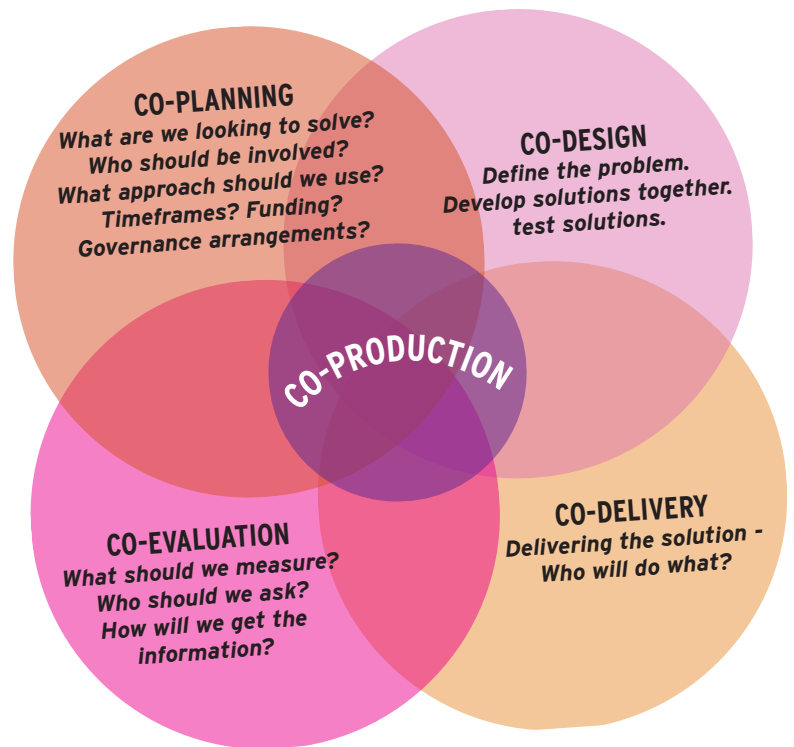


*Figure 1. What does co-production involve?*

*The most important part of co-production is shifting mindsets and establishing a culture that embraces exploration and learning, and genuinely values consumer knowledge and expertise.*

# Why should we co-produce?

- The knowledge and expertise of consumers is essential for creating quality services, programs or policies.
- Co-production provides a space for relationship building, knowledge sharing and capacity building of all partners involved. The benefits will often extend beyond the intended purpose of bringing partners together.
- Co-production identifies, validates and utilises service users' strengths, supports people's participation and fosters engagement between services and service users. Thus co–production very much fits within a recovery oriented framework (Department of Health [DoH], 2011).



# What can be co-produced?

Government, professionals, consumers and communities can be co-producers of ideas, solutions and outcomes in many areas, including:

- Services (including health and mental health services)
- Policy
- Projects
- Research
- Training

Co-production can be considered in almost any context where there are consumers or communities involved in or affected by the outcome.

# Types of consumer participation

Co-production sits within a spectrum of participation levels, as detailed in Arnstein's Ladder (Arnstein, 1969), ranging from exclusion through to citizen controlled (see Figure 2).

Governments and services should aim to seek the highest level of participation that is appropriate and possible. Not every project or initiative is suited to co-production, however applying co-production principles is particularly important for positioning consumers as leaders and creating safe and effective environments where consumer knowledge and expertise is valued and prioritised.

The bottom two rungs of Arnstein's ladder represent nonparticipation. Although the project may claim the consumer is 'involved', at these rungs consumers are not enabled to participate and instead are 'treated' or 'managed'. In "consumer participation" contexts, this may look like consumers being provided with a "script" for them to follow or environments where consumers believe that they are being invited into a consultative mechanism, but the organisers see the activity as "therapeutic".

Rungs 3 to 5 represent participation that may be considered tokenistic. Power holders here offer consumers opportunities to have input but there is little real control and power provided to the consumers (or relinquished by the power holders) to ensure their perspectives and contributions are given appropriate consideration. For example, consumers may be "informed" of decisions and met with defensive rationales for why their participation will not influence these decisions. Or consumers are "consulted" but no action is taken in response to their participation. Or consumers are "placated" by being hand-picked onto a committee where they are outnumbered and have no power to influence the agenda.

Co-production sits within the 'partnership' and/or 'delegation' rungs of Arnstein's ladder, where the former involves equal partnerships, involving negotiation and compromise, while the latter involves consumers taking the lead, but within an overall structure that is not necessarily consumer-led. At the top of Arnstein's ladder is full consumer control. This is not to suggest that consumer control is necessarily "better" than co-production, but to bear in mind that co-production is not the pinnacle of possibilities for consumer leadership. Many projects involve a hybrid between several different rungs - e.g. where consumer leadership redresses power imbalances in co-production. In some instances consultation (or even informing) is an honest description of engagement, where the rigors of full co-production are not feasible in the particular context.



Figure 2. Arnstein's ladder (1969) – degrees of citizen participation
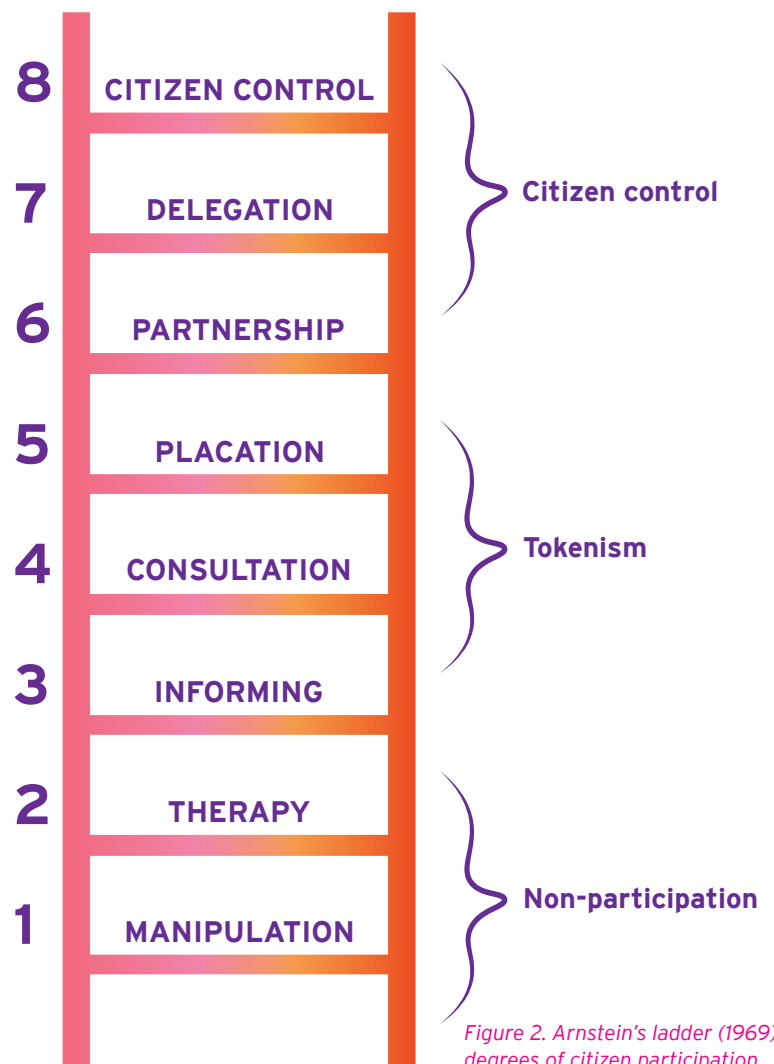
## Consumer perspective

Consumers bring more to co-production than their direct experiences of recovery and of using services and have more to offer than working to improve service quality for current service users. Over time, consumers have developed ways of knowing, theorising and thinking about their experiences that constitutes a unique discipline in the field of mental health known in Australia as consumer perspective. Consumer perspective contributes leadership, knowledge and expertise beyond the context of service improvement.

# How does co-production differ from other participation?

There can be multiple stages during the development and delivery of services or initiatives where consumers are partners, such as in co-planning, co-design, co-delivery, and co-evaluation. In co-production, consumers are partners throughout all of these stages. The real difference is how co-production deliberately sets out to create a culture that values all expertise and knowledge, particularly the expertise and knowledge of the people that are most affected by the problem and solution. Co-production recognises and seeks to address power differentials within partnerships. Co-production in mental health, therefore privileges consumer perspective, and promotes and develops consumer leadership, which shifts away from an historical positioning of 'professionals' as the experts that steer the agenda.

There are various engagement approaches, methodologies and tools (for example, relating to co-design, and co-evaluation) that are useful, however to co-produce means exploring and building (together) the philosophical foundations and mindsets from which other work can then be done. Co-planning, co-design, co-delivery, and co-evaluation, and other collaborative work can be undertaken without the culture shifting groundwork required for co-production. Some co-design approaches incorporate co-production activity, but many do not.

Other engagement methodologies may also be included as part of co-production, including consultation. For example, a co-production initiative may require extensive consultation with a number of stakeholders (including consumers external to the 'co-production' partnership) to obtain broader perspectives. Different people may participate at various stages of a co-production initiative, it is not necessarily the same cohort of people throughout. Consideration of what expertise and knowledge is needed at the different stages should inform who is involved, to what extent and when.

CO-PRODUCTION TAKES TIME

It takes time and care to establish trusting respectful relationships. It takes time and care to identify, discuss and address inequalities

# Co-production: core principles

There are three core principles underpinning co-production partnerships with consumers:

## 1. Consumers are partners from the outset

In co-production consumers are involved in setting the priorities and agenda and making decisions from the very beginning. Consumers are engaged for their thought leadership, experience and expertise and then throughout the enterprise. Consumers can also be engaged to lead projects.

All partners need a clear understanding of their shared purpose or aim. The purpose of the initiative should be revisited regularly so that outcomes are not compromised and the work of the group doesn't unintentionally veer off in a different direction.

A genuine partnership means that all parties are privy to information – there should be no partners that have privileged information about the initiative over another once co-production has started. If there are areas of confidentiality for specific reasons these should be made clear from the beginning.

## 2. Power differentials are acknowledged, explored, and addressed

Within groups that involve both consumer and non-consumer expertise, affirmative actions need to be taken to ensure consumer knowledge and expertise is privileged or else the more powerful group members will influence decisions.

In any partnership some partners are 'more equal' than others. Co-production means that the more powerful partners relinquish power and support empowering environments for others. Using a co-production methodology means the balance of power is challenged and consumers can exert influence. To avoid tokenism, harm or re-inscription of powerlessness and voicelessness, and to equalise power and influence, deliberate action usually needs to be taken, for example ensuring a project has a consumer majority or prioritises consumers' interests.

Cahn stresses that co-production is not necessarily smooth and co-operative, that it may involve confrontation or "take the form of a dialectic that yields parity, only after a struggle because the process entails a shift in status that may be embraced or resisted" (Cahn, 2000, p. 31). In co-production this tension must be addressed. It is only through the ongoing challenging of dominant, ingrained power roles that the value of co-produced work can be realised.

## 3. Consumer leadership and capacity is developed

The utilisation and development of consumer leadership is a feature of co-production in mental health. Consumers are thinkers and doers, not passive recipients of care, and they are holders of wisdom and knowledge no one else has. Building consumer capacity is a compensatory action for inequality in the same way that community development is a compensatory action to help build capacity where there is social exclusion, disadvantage or unequal access to the benefits of community. Additionally, services and service providers are likely to require building their own capacity around working with consumers. A discussion paper about co-production issues for policy and practice makes the point that:

*"if co-production has the possibility of bringing benefits to communities that would otherwise be excluded, then community development may well be required to help communities build the capacity to engage with service providers to take the relevant decisions and actions. Community development support may equally be needed with service providers to better equip them to engage with communities and in particular disadvantaged or excluded community interests" (Scottish Community Development Centre, 2011, p. 5).*

Co-production is a mechanism for learning and developing knowledge. A genuine partnership builds the capacity and harnesses the knowledge and skills of everyone involved – everyone has something to contribute and the exchange of these contributions is enriching for everyone, expertise no longer belongs to the professionals (Andrews, 2013).

# Power

Acknowledging, exploring and addressing power is an essential element of the co-production process.

Power is the ability to influence or control. Individuals have power. Groups and organisations have power. Power is not absolute, it is dynamic and relational. Power is exercised in social, political and economic relations, which means it shapes almost everything.

When power differentials are unacknowledged and unaddressed, individuals, groups or organisations with the most power will have the greatest influence, regardless of the quality of their ideas or skills.

When governments and organisations work with consumers there will be significant and obvious power differentials. There may be some power differentials that are less obvious, but still important to explore and address. Co-production is a way to genuinely shift and distribute power more evenly amongst partners, giving those with less power in the partnership more space to contribute and more influence than they would have in usual circumstances. This can be achieved through affirmative action, for example, proactively introducing consumer leadership and decision-making opportunities.



## Experiences of power in different contexts

### Mental health

Co-production needs to be considered in a particular light in the context of mental health because there is likely to be considerable power differential between consumer and non-consumer partners. While power differentials exist in all areas of life, in no other area of health care is there separate legislation that removes the rights of consumers to refuse medical treatment. This legislation means hospitalisation can be mandated, even if it is against a consumers wishes, and interventions such as seclusion and restraint are able to be authorised.

Mental health legislation interferes with a person's citizenship and autonomy – in some cases, throughout a person's lifetime. Even those who use public or private mental health services voluntarily are at risk of becoming subject to mental health legislation and compulsory treatment.

Some consumer partners involved in co-production initiatives may have experienced threats to or incursions on their self-determination, dignity and bodily integrity. Consumers often use such experiences to inform their work. Professionals may have difficulty framing such knowledge and expertise as legitimate and may have difficulty learning from consumers and positioning them as leaders. This can pose a risk to co-production.

It is important to recognise that power differentials that consumers have experienced may be perpetuated in a co-production environment when partnering with government, health professionals, and services, whether this is conscious or not.

# Non-consumer partners
## may need support to position themselves as
# LEARNERS
## and consumer partners
## may need support to position themselves as
# LEADERS
## within co-production groups.

**Government and organisational power in co-production**

Corporate bosses, governments, different government departments, unions and professions can be seen as 'challenging interests' to each other's power, which can create barriers to co-production when these partners come together with consumers. The political nature of government can mean there is a tendency for consumers to be 'captured' by powerful stakeholder groups. The potential for power struggles should not be overlooked when exploring what power and interests are brought to the table in a co-production context.

**Other contexts**

There are other institutional contexts in which people experience extreme power differentials. Families, for example, where authorities have removed children from care, asylum seekers in detention and people within the justice system are likely to have experienced power differentials at the extreme end of the spectrum.

# Old power and new power

There is a shift in power happening globally. Traditional economic and political power models still exist, but they are being challenged by increased community participation resulting in power being more broadly shared, for example, the collaborative economy that redistributes power from corporations (Etsy, AirBnB) and social media that redistributes power from the mainstream media giants. The old world is moving to new power models, but there is resistance, particularly from those holding "old power".

Hiemans and Timms (2014) describe old power as held by few and jealously guarded, with the powerful having a substantial store of it. It is closed, inaccessible, and leader-driven, enabled by what people or organizations own, know, or control that nobody else does – once old power models lose that, they lose their advantage.

New power is different, it is open, shared broadly and with transparency, it is participatory, and peer-driven (Hiemans & Timms, 2014). The goal with new power is not to hoard it but to channel it and through collaboration bring more ideas, expertise and resources to the table.

## OLD POWER VALUES

| | NEW POWER VALUES |
|---|---|
| Managerialism, institutionalism, representative governance | Informal, opt-in decision making; self-organisation; networked governance |
| Exclusivity, competition, authority, resource consolidation | Open source collaboration, crowd wisdom, sharing |
| Discretion, confidentiality, separation between private and public spheres | Radical transparency |
| Professionalism, specialisation | Do-it-ourselves, "maker culture" |
| Long-term affiliation and loyalty, less overall participation | Short-term, conditional affiliation; more overall participation |

*Figure 3. Old power vs. New power*
*Source: Jeremy Heimans and Henry Timms, 2014.*

*"Co-production takes time and care, and requires attention be given to how power is experienced by everyone involved."*

*Source: Heiman and Timms, 2014*

# Bringing power to awareness

One of the first steps for any co-production initiative should be to identify and acknowledge power imbalances. But how can power be brought to awareness? In a co-production context, open and frank discussions about what power differentials exist within the group is needed. This is not easy and can be incredibly uncomfortable for people.

There will be some obvious power differences that can be easily identified, for example, someone representing an organisation such as a government department or professional body, will likely have a great deal of power in relation to others in the group. A consumer that has not been involved in collaborative work before and is less experienced at putting forward their perspective may have less power in relation to a consumer that has decades of consumer advocacy experience, if action isn't taken to increase their ability to influence.

Identifying power differentials in a discussion may not be difficult when they are obvious. A group may decide to explicitly map out where power sits within their group on a whiteboard or by using a template such as the one provided in Appendix E.

# Addressing power imbalances

Co-production is often described as involving 'equal and reciprocal relationships' (Slay & Stephens, 2013, p. 4), but this aspirational statement is not always accompanied by practical guidance on how to shift relationships so they become more equal. How can we move from the more traditional, hierarchical relationships to ones where issues of power are consciously attended to and addressed? Once power differentials have been identified, action should be taken to shift power in the direction of those with less power, for example:

- Prioritise consumers' interests
- Support and resource consumers to take the lead on projects
- Consumers set meeting agendas and decide what time should be spent on particular topics/activities
- Consumers could create a 'deed' of expectations that everyone in the group signs up to
- Ensure the initiative has a consumer majority
- Establish a consumer steering group to provide governance

- Toward the start of meetings, acknowledge people that have experienced or are experiencing a loss of power when engaging with the service system, as a reminder of why power is being closely attended to
- Those with more power can physically step out of the space to give those with less power an opportunity to consider or discuss without a power imbalance
- Set aside regular times to review how the partnership is going
- Factor in time, thought, effort and planning at all stages of the partnership for the purposes of noting, voicing, tabling and addressing power differentials
- Discretionary funds that can be used without question to support the objectives of the group
- Creating a 'group lexicon' - 'unhelpful' language could be identified (usually, but not always) by consumers and alternative words used within the co-production space.

There are endless creative ways in which power and influence can be re-distributed. It is important that co-production participants develop these strategies, and that consumers in particular take a lead on deciding what is helpful and what will be done.

# The challenges of co-production

Co-production is challenging – it requires examination of processes and power at the organisational level and within groups, and requires participants to continuously explore power at an individual level. Because of the dynamic nature of power, it needs constant focus and attention to ensure its even distribution throughout the life of the initiative.

Co-production can create power-sharing risks and dynamics that all partners may need support to navigate (Consumers of Mental Health WA, 2015). The process will likely feel uncomfortable or difficult for different people at different times.

It can be challenging for government departments and organisations to share control of policy making, and there needs to be appropriate influence at the right level to support this to happen. Departure from normal organisational processes may be needed to facilitate co-production, and again, the right level of support and influence is needed to ensure this can happen.

Co-production presents multiple challenges for organisations, including government. Resourcing constraints, a drive for rapid progress, lack of co-production expertise, and existing organisational policies can all be barriers to robust co-production.

Not everything can be co-produced. There are certain situations where co-production might not be an appropriate approach, for example, when targets are pre-defined and are in conflict with what consumers see as important. Some initiatives may be highly confidential or time-critical, and consultation might be the highest level of participation that can be achieved.

It is important that services and governments are honest about the level of consumer participation that can be achieved in each situation and that the term co-production is not co-opted to describe participation that is actually on the lower rungs of the participation ladder.

# Critical elements for co-production

1. Everyone involved in the initiative is on board with co-production and the initiative, and is willing to advocate for both. Half-hearted involvement of individuals or organisations will not be enough to carry the work of the group forward and may be detrimental.
2. If there is an organisational context, leaders and decision makers within the relevant organisations understand and support both co-production and the initiative before it starts.
3. There is a willingness from all involved to take risks. Co-production represents a new way of approaching work and partnerships. Managed, considered risk-taking is necessary to realise the benefits of new power and the different ways of working that will be discovered.
4. Access to co-production expertise and support is needed if people within the group do not have this capability.

# Preparing for co-production

## Setting the agenda

A critical question for co-production is how the agenda is set and who decides. The agenda can be set by consumer members of the partnership, by non-consumers (see Figure 4), or it can be arrived at together. While each of these modes require that attention is given to maximising the voice and needs of the consumer side of the partnership to offset inequalities, the most reliable way to ensure this is for consumers to set the agenda and lead the work.
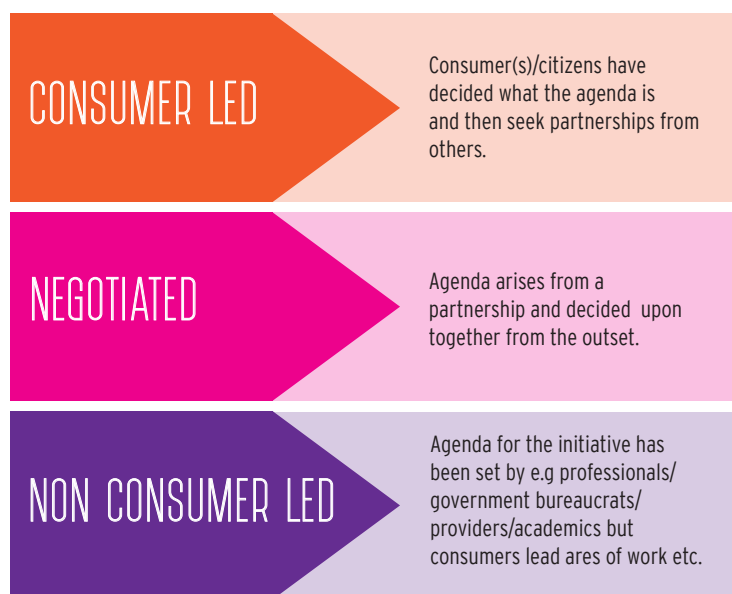
| CONSUMER LED | Consumer(s)/citizens have decided what the agenda is and then seek partnerships from others. |
| NEGOTIATED | Agenda arises from a partnership and decided upon together from the outset. |
| NON CONSUMER LED | Agenda for the initiative has been set by e.g professionals/government bureaucrats/providers/academics but consumers lead ares of work etc. |

*Figure 4. Different approaches to agenda setting*
*Source: Roper, C, 2016 p.20*

## Who should be involved?

A great deal of consideration should be given to who needs to be involved in the initiative. What expertise, professional, consumer or otherwise, will be needed to make the proposed initiative a success? Subject matter expertise and lived experience expertise relevant to the context will be needed as a minimum. Expertise to navigate any organisational processes, project management expertise, co-production expertise, and people that can support any communication or engagement that is critical to the initiative success might also be needed.

## Consumer expertise

When preparing for co-production, it is essential to reflect on what consumer expertise is sought and why. Below are some useful questions that may assist in understanding:

· Will the expertise of local consumers be central (the people that will be directly affected by the initiative and have the greatest stake in it)?

· Will the input of consumer leaders with specific expertise be sought? For example, if it is a professional development initiative it might be appropriate to work with consumer leaders with expertise in adult learning, education and training. If it is an initiative to be implemented in an acute setting, seek out consumer leaders with acute setting experience and expertise. (Examples of other areas of expertise include peer support, research, workforce issues, supported decision-making and recovery)

· Do you know which consumers have the expertise you're looking for or how to find out?

· Do you know who the local consumer groups/organisations are?

· Will a process of engagement with formal consumer-run organisations and/or informal consumer groups need to be planned?

· What is the highest level of consumer input that would be appropriate - consultation, consumer participation, co-production, or consumer leadership? Are there parts of the project that could be consumer led?

· What is it that each partner in the initiative can learn from using co-production methods in the proposed action/project?

· What is it that the consumer partner can offer/do that nobody else can offer/do?

## What else needs to be considered?

Once a co-production methodology has been decided on and co-production partners have been identified, there are a number of other questions that should be considered before deciding how to proceed.

*See Appendix A. Questions for consideration prior to co-production.*

# Bringing co-production partners together

There are many decisions to make that will be unique to each co-production initiative, however there are a number of items and questions that should ideally be addressed at the commencement, and again throughout, any co-production initiative.
To support these initial stages this resource includes a number of tools and resources:

- Questions for discussion when bringing co-production partners together (Appendix B).
- Sample agenda for first-time meetings with co-production partners (Appendix C)
- Ideas for ice-breakers (Appendix D)
- Mapping power - and points for discussion around distribution of power (Appendix E)

TRUST AND RESPECT on all sides is essential to enable mutual learning and understanding of the issues, dilemmas, constraints and POSSIBILITIES FOR CHANGE

HASHAGEN ET AL 2011, P. 14

ALMOST ALWAYS
THE CREATIVE
DEDICATED
MINORITY HAS
MADE THE WORLD
BETTER

-MARTIN LUTHER
KING JR.

# Lessons from a co-production project

## Emma Cadogan – Consumer Workforce Development Group

The Consumer Workforce Development Group was established to explore co-production while looking at consumer workforce issues and solutions. This brought together Department of Health and Human Services (DHHS) staff with consumer workers and introduced a new way of working for people involved. The group is comprised of consumers that have a wealth of experience, knowledge and consumer workforce related connections across various mental health services and organisations. Two DHHS contributors bring policy and strategy expertise and support bringing the group's objectives to fruition through government levers. During the time the group has been together, a vision for the Consumer Workforce has been developed, and several initiatives have had beginnings within this group, for example, a statewide workforce development program for peer support workers and their organisations.

Although no single co-produced initiative will be the same as another, I have detailed some lessons from the establishment of this co-production group from my perspective as a project manager. Although the project was implemented within a government context, many of the lessons will be relevant for other organisations. Consumer perspective case studies from other projects can be found on page 22.

1. **Business as usual processes can be a barrier to co-production**
   The processes and tools used in everyday business have likely been developed for a specific workplace, context and setting. They might not suit everyone involved in the co-production group, and adopting existing processes inadvertently influence decisions and outcomes. Processes such as communication channels and how meetings are organised need to be discussed and agreed upon by the group.

2. **Think carefully about whether the project is appropriate for co-production**
   Resources are limited. It is important to focus on co-producing initiatives that are likely to bring about significant change and improvement. Some initiatives will be more suited to co-production than others - timelines, resources and the commitment of participants might influence the decision to co-produce or not. There is risk associated with not co-producing, and there are lots of examples of projects and programs that have not achieved the intended outcome because of insufficient involvement of end users in planning, design, delivery and evaluation.

3. **Ensure that any co-production project has adequate support at the right levels**
   Once a co-production project is started, failing to follow through with the co-production process presents a risk to participants and the established relationships. For a co-production initiative to be successful it needs to have organisational commitment from the outset and should be sustainable beyond any particular individual's involvement. A champion for the initiative at an authorising level is essential to securing appropriate resourcing (such as funding).

4. **Don't let fear of failure stop a co-production initiative**
   Changing course mid-stream needs to be seen as an important learning that could not have been otherwise discovered, rather than a failure. Initiatives and services that miss the opportunity to engage the appropriate expertise at the right stages are less likely to improve outcomes.

5. **Get comfortable with focussing on process**
   A focus on process may be challenging for some people – especially for those that are accustomed to managing projects that have timelines, outputs and processes defined at the start. In co-production, the outcome is driven by the process, therefore it is important for everyone involved to shape the process. There will need to be experimentation with different ways of working together, which requires a slower, more deliberate pace.

**6. Invest in building relationships**

Establishing collaborative relationships is essential to successful co-production. Trust is paramount. The group needs to work together and be open to learning from each other – mutual learning is one of the major benefits to using co-production methodology. Action learning can be an effective approach to support positive relationships and build capacity of individuals.

**7. Build a platform for co-production within your organisation**

In addition to investing in building relationships within the co-production group it is important to consider building internal relationships within organisations that can support co-production. If there are different teams from an organisation involved in an initiative, positive relationships need to be in place across those teams to build a platform for co-production that can be shared with external partners.

**8. Acknowledge participant contributions and understand motivations**

It is helpful to identify the expertise that individuals bring to the group and to acknowledge why and where particular knowledge is needed. Participants will have different reasons for being part of the group. It is helpful to understand what their motivation is and to keep reflecting on whether the work is meeting the needs and expectations of the group and of the individuals involved.

**9. Keep asking questions**

In the beginning, with no project definition or parameters, all there may be is a list of questions. All participants will have their own questions and work will take shape as these questions are explored.

**10. Establish a shared purpose, scope and principles for working together**

Agreeing on the scope is important – this may take some time before it can be defined. Participants will also want to discuss and agree on a shared purpose, and principles for working together.

**11. Allow sufficient time**

A good solution usually requires a problem to be well understood, therefore it makes sense to spend time exploring the problem from different perspectives. Timelines may need to be extended and decisions may take longer than planned, however, this depends on the priorities set by the group and the urgency for completing particular tasks.

**12. Communication is key**

It is important to maintain enthusiasm and momentum for the co-production initiative. This means communicating successes, progress and achievements to stakeholders throughout the project duration. It is also important to keep checking in with the co-production group not only as a group, but also at an individual level - sometimes what people say and do in a group can be different to how they are really feeling or thinking.

**13. Participants need a shared understanding**

All participants need an equal understanding of terminology, definitions and to have access to any information about the initiative and processes to allow co-production to occur. For example, a common understanding of what is meant by the term 'peer work' would be needed in the context of an initiative to support peer work.

# Co-production in practice - case studies

The following case studies highlight some Victorian consumer-led initiatives that embody the principles of co-production.

## The Understanding & Involvement (U&I) Project

**Interview with Merinda Epstein**

U&I was a ground-breaking Participatory Action Research (PAR) project contributed to by consumers from the Victorian Mental Illness Awareness Council (VMIAC) in the early 1990s.

The project produced five volumes of work:

- Understanding Anytime – a consumer evaluation of an acute psychiatric hospital

- Consumer Evaluation of Acute Psychiatric Hospital Practice: A Project's Beginning... (Vol. 1)

- Consumer Evaluation of Acute Psychiatric Hospital Practice: A Project Unfolds... (Vol. 2)

- Consumer Evaluation of Acute Psychiatric Hospital Practice: A Project Concludes... (Vol. 3)

- The Essential U&I – a one volume presentation of the findings of a lengthy grounded study of whole systems change towards staff-consumer collaboration for enhancing mental health services.

The project developed a series of newsletters which were designed to communicate with the several hundred consumers and staff actively involved in the project.

In many ways the project was also a clinical education project as it brought the opinions of consumers about acute hospital experiences to clinicians, and as the project developed, started to systematically ask the clinicians how they could work differently in response to the stories of practice that consumers were telling. The clinicians' suggestions were provided back to consumers for comment and the 'communication snake' would continue with the work team acting as a conduit between the two groups. With each loop back and forth the difference between positions decreased. This enabled communication, minimised confrontation and freed consumers from their assumed role of placating staff.

The U&I project emerged from a completely localised, grounded, response from a consumer organisation's demand that something must be done to change acute services and that this must be driven by consumers. The role of the U&I Project was to seek multiple ways to enact new policy directions that supported consumer participation.

Funding for the project was provided to VMIAC from the then Department of Human Services. Yoland Wadsworth, an evaluation expert and one of the driving forces behind the project, encouraged VMIAC to do more than the proposed acute unit exit survey, and together they successfully gained funding for a 3-year project. The significance was that hitherto no consumer-led research endeavours had ever received three years funding, especially not in an acute setting. There was a project team of about 15 paid positions within VMIAC that worked on the project at different stages.

### Were consumers partners from the outset of the project?

The project was consumer driven and service collaborative from the beginning, but time was needed to figure out how to make this work. Initially there was a typical steering committee that included consumers, clinicians, administrators, and community visitors. It was purely a governance committee but with a twist - it attracted the disaffected from all camps and was proud to do so; however it was collectively decided that in that format it was limited by procedural requirements such as agendas, minutes and governance. This was not the best way to utilise the talent, drive, expertise and work ethic of committee members from all the different groups. The steering committee was abandoned in favour of a 'Collaborative Committee' – made up of exactly the same membership but with a very different role.

The Collaborative Committee was new, exciting and consciously developed. Governance went back to the consumer organisation which dealt with it competently. The Collaborative Committee became proactive, experimental and a place where conversations were included as part of the research data collection. The difference between those doing the research and the researched-on was deliberately minimised.

### Was it an equal partnership, were power differentials explored at any point?

At its core the project always involved an equal number of consumer, clinicians and staff, to get the balance right. The project team believed that a critical mass of consumers was essential but as trusting relationships developed there was less need to take this so literally. In the more removed rings of project participation many different groups were engaged for specific purposes.

### Was consumer capacity/leadership increased as a result of this program?

Consumer capacity was built through people realising that they had worth and an identity other than a 'sick person'. Often people were recruited straight from acute units. This movement from patient to evaluator/researcher not only enabled a diverse group of consumers to learn concrete research skills but it also surprised clinicians at the time when previous patients arrived back with a new persona. It was difficult but important for these relationships to be renegotiated.
This project saw the start of consumer consultant roles. The first consultants (in 1995) were actually called staff-consumer consultants as recommended by the U&I project. The hyphenation was intended to make it clear that the consumer role was, in part, to instruct staff about what action was needed. Clinicians still had responsibility to do their job which now included changing their practice in an ongoing way in the light of consumer insight. Developing skills in communicating the consumer body of knowledge in a confident and measured way was new to everyone.

### What advice would you give to participants of a co-production project?

Be careful. Tread warily. Allow meanings to emerge from the process. Don't demand immediate answers. There are other differences between people, that influence process and sometimes these are more important than consumer, clinician, administrator, bureaucrat identities, such as social class, education, gender. To keep integrity in coproduction, and avoid the end product being 'engineered' there must always be multiple mechanisms for engagement.

If you are not a consumer don't try too hard to help us. Sit with uncertainty. Be honest. Say when it seems too hard. Don't try to be perfect but endeavour to be thoughtful. Don't over valorise consumers. This is as bad as underdoing it but don't worry too much about this either because if you do you will be walking on egg shells and this will hurt your feet and may come across as contrived.

The effort needs to go both ways. It is not up to non-consumers to take all the running although it is equally not about matched reciprocity.

The U&I project taught us that a consumer-driven/staff collaborative project must work very hard to hold a privileged place for consumer knowledge. This was the hardest thing to do and the most important. Deliberate attention to holding the torrent of everyday power assumptions from swamping the project was essential. Sometimes efforts to maintain this might have been seen as biased or uneven. We used linguistic markers to check how we were going. As language changed so did practice. We collected lists. One assumption, amongst many, was that 'clinicians know and consumers only perceive'.

### Do you have any specific advice for bureaucrats that would like to work with consumers in this way?

The question needs to be asked 'can we really do this, or are we kidding ourselves?' There is nothing wrong with having an approximation of co-production - just don't pretend it is something that it isn't. Consumers will know when something is not genuine. Be honest. Be humble. Ask questions, do not give answers.

Remember many consumers have been systematically taught to distrust themselves and over-trust 'the system'. Sometimes it is important that non-consumers take the lead. This is not wrong.

Hold a space for consumers when they are silenced by power that might be held in the position or title of the bureaucrat, the building with its many floors that holds bureaucracy, the forbidding technology, acronyms, linguistic shortcuts, naming people who others don't know, the form letters or even the security swipe cards. The point is not that this can always be solved but rather that the real fears of everyone be welcomed as part of good process and no one is left feeling silly and incompetent. The hidden curriculum undermines more than an overt one. In the U&I project we created a safe consumer place with the hospital, within the bureaucracy, as best we could.

What is the place of a governance-type, bureaucratic-type, correct set of skills? This needs to be sorted early. The U&I found that these skills were secondary to more creative capabilities in terms of generating knowledge and pushing forward real possibilities for change. Honouring this learning will be a challenge for bureaucracies. Possibly the most pivotal intelligence to come out of the U&I Project was the nature of epistemology in a bureaucratic context and this cuts across boundaries between consumer and bureaucrat.

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# Electro Convulsive Therapy (ECT) dialogue tool project, North Western Mental Health, 2001-2003

**Interview with Wanda Bennetts**

The development of the electroconvulsive therapy (ECT) dialogue tool was an initiative of the Consumer Advisory Group (CAG) at NorthWestern Mental Health. The CAG would invite guests to its monthly meetings. The ECT nurse was invited to one of the CAG meetings.  Following a presentation from the ECT nurse, CAG members observed that the information provided was not what they had wanted to know while there was lots of other information they had wanted to know that wasn't covered.

The group decided they wanted to ask their own questions about ECT and began a project to develop a dialogue tool that could stimulate conversation between consumers and clinicians.  Rather than clinicians handing out printed information for consumers to take away, the dialogue tool would support the beginning of a consultative process.

The purpose of the tool was to ensure open conversations about treatment options and alternatives. Openness about treatment options and alternatives is particularly important in the context of mental health because of the potential for treatment decisions to be made on behalf of consumers and for consumers not to have a say.   The tool was developed:

·   To encourage consumers to ask all the questions they need to ask about ECT

·   To make consumers feel as comfortable as possible when asking the questions (including reassurance that all questions are valid and important)

·   To encourage consumers to be able to make more informed choices about treatment choices and options

·   To improve information available about ECT

The dialogue tool is founded on supported decision-making principles by beginning with the question: "Let's ask consumers what they want to know about ECT", rather than clinicians assuming what's important to tell consumers. After gathering these questions from consumers, clinical expertise was sought to review the consumer questions and provide accurate answers. This became the basis for the dialogue tool. Before clinicians could use the tool, they needed to attend a presentation explaining the background to the development of the tool, the purpose, and how to use it. The presentation was developed by the consumer consultant with the CAG.

'I WANTED TO RAISE AWARENESS. Nobody got their copies of the dialogue tool until they'd had the presentation about it. This included: THE HISTORY OF THE PROJECT THE INTENT OF IT, HOW TO USE THE TOOL AND TO HEED WHAT CONSUMERS SAY.'

The project was discussed at service quality committee meetings, operations committee meetings and in the ECT committee. Money was provided for CAG working groups to progress the project and the tool was professionally published.

### Were consumers partners from the outset of the program/project?

The idea for the project emerged from consumers in the CAG and was led by the Consumer Consultant so it was consumer led and co-produced. Clinicians were invited into the consumer space and working partnerships were formed with clinicians, as clinicians and the service became involved in reviewing the tool, providing feedback and financing its ongoing development. For the CAG this resulted in an enhanced reputation and put it 'on the map' for the service. While the project was something that the service could see value in, it was done "our way".

### Was it an equal partnership? Were power differentials discussed or explored at any point?

Principles of co-production were reflected in the way that consumer expertise led the development of questions and clinical expertise was sought in providing answers to those questions. Where positions had to be negotiated, as a consumer led project, consumer perspective held sway. For example, when the ECT committee suggested changing the text to read "things you need to know" about ECT the CAG's response was to hold strong and say it was about encouraging consumers to ask about "things you want to know". When ECT was described as an "effective treatment" the CAG dropped the word "effective" on grounds it reflected a judgment. When the committee recommended covering

more information, the CAG insisted that they wanted less information and retain the larger font size for ease of reading. The CAG was a barometer for the language used in the dialogue tool and was also the ultimate decision-making body. ### Was consumer capacity/leadership increased as a result of this program/project?

An inclusive, educative space was created in the CAG so that nobody got left behind. The project created energy within the group; a sense that 'we can do this'. There was a sense of pride, people felt valued, the service resourced it, people had ownership over it, and they felt they had done something of use to other consumers. The tool was rolled out across the whole service. Another positive outcome was that clinicians saw how a consumer space worked, they saw its value and the value of consumer perspective. The project also gave the service a sense of what's possible with a CAG. After this, people in the organisation started to use the group in ways that then felt appropriate.

### What advice would you give to participants of a co-production project? Do you have any specific advice for bureaucrats that would like work with consumers in this way?

Our success in part was due to naiveté. It unfolded naturally. We didn't think. 'Oh, we can't do that because of xyz'. We worked out what was needed each step of the way, and then we met those needs. It was an organic process. We just did it. We didn't know what we were doing was co-production.

I would say don't overthink things. The minute you realise you've got an idea, bring people together. Bring consumers in. Disobey traditional thinking where you think you have to have developed something substantial before you bring people in. Tap into the consumers and let them develop the idea.

## Psych Action & Training Group (PAT)
### Growing consumer perspective in academia
*Cath Roper*

*The Centre for Psychiatric Nursing (CPN) facilitates the trans-disciplinary Psych Action and Training Group (PAT) at the University of Melbourne. PAT works co-productively to promote service user leadership in the areas of research, education/ training and policy development.*

In the context of academia, co-production occurs when work/ initiatives are developed and delivered through equal and mutual relationships between service users, academics and clinicians. The principles of co-production are adopted in the

PAT group through a belief in the transformative power of bringing together lived experience knowledge and expertise with academic and professional knowledge and expertise.

Service user leadership is PAT's preferred approach to co-production. Service user leadership occurs when first person lived experience thinking, knowledge and expertise underpins shapes and drives the work or initiative from the outset, where service users are resourced to take the lead.

PAT operates as a discussion-based 'brains trust', providing mutual and collegial support for its members. The group provides thought leadership and is an intellectual proving ground from which to critique existing practices and paradigms and generate new ideas. Members have described the group as a place of nourishment for work, a solace in the face of isolation, and a place of ethical attentiveness that celebrates different ways of knowing.

### History and structure of PAT

The PAT group is facilitated by the CPN's Consumer Academic and began in 2002 as a means of harnessing, supporting and promoting consumer perspective within the CPN and within the mental health service system through the work of its members. In its early days, the group was co-facilitated with an employee of the Victorian Mental Illness Awareness Council and the two organisations collaborated to 'skill build' amongst the consumer community by developing and delivering training to support consumer educators to confidently train clinicians.

The PAT group comprises consumer perspective, and academics from mental health nursing and occupational therapy fields. It has a virtual membership of over 40 individuals of which a small number come together for face to face meetings every six to seven weeks. Consumer PAT members who do not work full time are paid for their expertise.

Among its activities, PAT has provided advice to the Victorian Department of Health and Human Services Mental Health Branch; made submissions on government policy and to Commonwealth Senate select enquiries; provided critical feedback on the research of higher degree students; contributed to the development and delivery of professional development sessions to clinicians; provided advice on research projects internal and external to the Centre for Psychiatric Nursing; and has hosted workshops and events to promote the work of local, interstate and international consumer guests. Members have collaborated to write

position papers, discussion papers and presentations. PAT is a vehicle for bringing service user and lived experience knowledge into the academy; for developing service user and lived experience knowledge and expertise as a substantial discipline; and for applying this discipline in creative ways.

The group has had many discussions about co-production and consumer leadership. The advice we would give to bureaucrats wishing to work using the principles of co-production would be to resource consumer thinking from the outset. Generally, we are asked for our opinion about projects well after they have already been planned and budgeted for and after the parameters of the work have already been set. Meanwhile, as project workers who are not consumers struggle to come to terms with the concept of co-production, consumers who are fully immersed in co-production techniques are often only sought for their advice, are not paid, and their expertise is underused, rather than being engaged to undertake the project work. This can result in frustration and work of lesser quality that does not meet people's needs.

The paradigm shift of co-production in the context of mental health is that service users and people with lived experience lead.

For more information about the PAT group or to engage the expertise of this group, please contact Cath Roper via email: croper@unimelb.edu.au or telephone: 03 8344 9455.

## Mental Health Experience Co-design (MH ECO)

**Wayne Weavell**

Mental Health Experience Co-design (MH ECO) was a co-design methodology originating from a need to do something positive with data acquired through an experience based survey developed for the Victorian Department of Health and Human Services in 2006-2007. MH ECO was based on Experience Based Co-Design (EBCD) principles originally developed by Bate and Robert in England. Bate and Robert formulated EBCD for health services such as cancer support services. MH ECO has been specifically designed for applications in mental health settings.

The methodology was developed through partnership between the peak Victorian consumer body (VMIAC) and the peak Victorian Carer body (Tandem Carers). The work was carried out by a combined consumer and carer research team.

MH ECO development was funded by the Victorian Department of Health and Human Services for about 5 years at the end of which a toolkit for the methodology was completed. There is a website concerned with MH ECO that describes in detail the philosophy and development of the methodology: www.mheco.org.au

*Were consumers partners from the outset of the program/project?*

Yes. A central tenet of MH ECO is the establishment of a 'level playing field' environment where everyone's participation and experience are equally valued.

*Was it an equal partnership? Were power differentials discussed or explored at any point?*

The aim is always equal partnership of consumers, carers and service delivery staff. Power differentials are thoroughly discussed in the training for participation sessions that are an intrinsic part of the methodology.

*Was consumer capacity/leadership increased as a result of this program/project?*

Yes. Capacity building for co-design uptake is a goal of the MH ECO process. In some cases, after projects have been completed, consumers have said that they feel more empowered and confident to undertake other projects within their service and externally. Several consumers have gone on to express a desire to take up consumer peer worker roles and become more involved in the consumer environment.

*How could aspects of the project be improved to better align with co-production?*

MH ECO is a co-design methodology and as such could be considered to be a vital part of co-production. It involves gathering experience based data and using it to co-design parts of a service in partnerships between stakeholders.

*What advice would you give to participants of a co-production project? Do you have any specific advice for bureaucrats that would like work with consumers in this way?*

Mutual trust and respect are pivotal to the MH ECO way of working together in equality based partnerships. Lack of these factors can become a significant barrier to a successful outcome and must be established early in the project. Establishing a level playing field ethic from the project outset is vital so that everyone can feel safe and confident in providing their input and knowing that it is just as valid as that of anyone else.

# Mind Recovery College

**Dianne Hardy and Graham Panther**

The Mind Recovery College is where real people with real life experience share what works. The college teachers are people with lived experience of mental health issues. Some are qualified educators in their own right, others are first-time teachers, supported by the team to design courses based on what they've learned in life or through their professional roles. This helps ensure courses are truly informative and

useful to people seeking mental wellbeing. Mind Recovery College courses are available at a small cost, and can be included in an NDIS support package. Some courses run for a few hours over one day, others run over several sessions, usually for one session per week. There are eight campuses across Victoria and two campuses in South Australia. The College was selected for a National Disability Award for Excellence in Choice and Control in Service Delivery in 2015.

The Mind Recovery College was initiated by two of the organisation's senior executives after they had the opportunity to see recovery colleges in action in the United Kingdom. With consumer involvement, the founders took steps to develop a comprehensive concept paper and then a business case to seek philanthropic funding for establishing the college.

In this project, co-production was seen not just as a mechanism and a way to do the work, but also as a way to shift culture. For example, moving away from the "doctor knows best" attitude is moving towards valuing what is learned from life experience. A natural first step, then, is to recruit staff with lived experience of mental distress. For any person it is difficult to perform a job without the attributes, knowledge and skills required to undertake the work, therefore it has been important to ensure every person's capabilities are well matched to the work. The vast majority of Mind Recovery College team members have lived experience of mental distress. Each team member's role title reflects the work they do – for instance, "Learning and Development Consultant", rather than "Peer Educator". For most roles, the job description clearly lays out an expectation for that worker to draw on their personal experience in their work. In general, the college strives for a culture in which everyone values their 'messy' life experiences for the learning they can bring.

The language and beliefs that were brought to the project were around 'doing things together' rather than the language of 'partnership'. As an example, the founders hired two project leads to establish the college, and both brought lived experience of mental distress, along with a range of other relevant expertise; so from the outset consumer experience was installed at a decision-making level. The project was committed to a co-production approach where people were valued for both their life experience as well as their skill sets. Co-production was seen as a way for people to come to the table but not be hemmed into their roles or discourse such as the 'consumer' being in need of therapy or the 'professional' expected to have all of the answers.

The co-production model developed and adopted by the Mind Recovery College brings together life experience, subject matter expertise and learning and development expertise.

This model was reflected in governance and management structures for the college. Members of the Project Governance Committee and Local Working Groups brought consumer and carer experience.

The Mind Recovery College started by holding conversations with groups of clients, carers and family members to discuss three questions:

- What would you want to learn?
- What would you want to teach?
- What would make it easy to participate?

The college team found that having an educational focus brought about new possibilities and a new space for discourse that was created through conversation about ideas, thoughts, and feelings as people heard each other's views. From these sessions a draft curriculum for the Mind Recovery College was developed.

An education based model that supports recovery is different from what the mental health service model provides – the Mind Recovery College does not attempt to replace or duplicate mental health services. Activities at the college have an emphasis on education, using education-based language and structure; for example when people suggested courses in January would be good because people often do not have as much to do at that time of year, activities were reframed as "summer school".

Mind Recovery College leaders bring their lived experience in addition to other learning and development capabilities. Good facilitation techniques were key to addressing any power differentials and ensuring that the quietest voices were heard, and to set up the space to prepare people's expectations from the beginning. This was a space for people to be honest about what they didn't know, to voice doubt, to trade ideas and actively listen and sit with other people's experience. People would connect with each other over a mutual interest in gardening or having a pet, rather than staying within their role. In workshops students are asked to introduce themselves by name and by noting some personal interest, this tends to avoid the common mental health practice of introducing yourself by job title or diagnosis.

Having a senior decision-maker on the Project Governance Committee from the college helped to ensure that the project ran to time and supported the provision of timely feedback and strategic understanding. Senior backing with a genuine understanding and belief in an 'adventuring', experiential

approach to bringing about innovation was also important because the team needed to know that the organisation was serious about this new way of working. For example, it might involve talking in ways people might not be comfortable or familiar with, publishing things that others might not agree with, and being open to having new conversations.

A barrier to co-production in the context of Recovery Colleges could occur if people involved were not open to self-examination. For example, if a facilitator at the college had themselves found medications unhelpful, they needed to be able to put that aside to allow conversations that explored both the pros and cons of medications. Another potential barrier is that co-production and innovation would be hard to do if there is little organisational support for risk taking or system development.

For more information about Mind Recovery College and the courses offered visit: http://www.recoverycollege.org.au/

**Practical guide: Progressing transformative co-production in mental health**
https://www.ndti.org.uk/uploads/files/MH_Coproduction_guide.pdf

## CO-PRODUCTION OF RESEARCH

**Co-production in mental health research provides opportunities to capacity build and offers a different perspectives to clincians and academics, with service users potentially having different priorities for a research agenda.**

**Small voices, big noises - lay involvement in health research, lessons from other fields (Baxter et al., 2001) outlines key success factors in designing collaborative research, that include a shared empowering philosophy; building shared values; common language; and flexible research design.**

**An example of co-production in research is the St Vincent's Hospital consumer evaluation of strengths-based case management model. This research used a narrative approach to capture people's experiences of case management and was co-produced by consumer and multidisciplinary researchers.**

**The resulting book is available on the "Tools for Change" Mental Health Recovery website:**

**recoverylibrary.unimelb.edu.au/domains/strengths**

# Useful resources

**Practical guide: Progressing transformative co-production in mental health**
https://www.ndti.org.uk/uploads/files/MH_Coproduction_guide.pdf
This guide sets out some practice-based advice on what needs to be considered for progressing towards 'transformative coproduction', specifically in mental health. It is aimed at everyone with a practical interest in making co-production work in mental health services.

**Position paper: Are mainstream mental health services ready to progress transformative co-production? - National Development Team for Inclusion**
https://www.ndti.org.uk/uploads/files/MH_Coproduction_position_paper.pdf
This position paper is aimed at everyone with an interest in understanding the challenges for progressing co-production work in mental health services. It is particularly designed for those involved in mental health policy and development as well as service users and practitioners who want to engage with and understand transformative co-production in mental health.

**Stories of co-production – The New Economics Foundation**
https://www.youtube.com/watch?v=aKATrzUV2YI
Co-production is about involving people in the services they use. This video features people's stories of co-production experiences.

**No more throw away people: the parable of the blobs and the squares**
https://www.youtube.com/watch?v=C107PQ3h8Kk
Edgar Cahn in his book No More Throw-Away People relates the parable of the Blobs and Squares to explain the co-production imperative. This video co-produced by Time Banking UK retells the story.

**Working together for change - co-production commissioning for transition**
www.youtube.com/watch?v=EiXTBiqL7EQ
This animated drawing explains the benefits of working together for change.

**Centre for Coproduction in Mental Health, Middlesex University London**
www.mdx.ac.us/our-research/centres/centre-for-coproduction-in-mental-health
Led by Associate Professor Sarah Carr, this research institute produces publications and holds regular conferences bringing together internationally-recognised leaders in co-production in mental health.

**The Scottish Co-production Network**
http://www.co-productionscotland.org.uk/
This website features a suite of resources – videos, case studies and information to help spread understanding of co-production. It gives examples of the different ways in which co-production approaches can be used, but more than this, it draws together the principles of co-production and the practicalities of working in this way.

**Scottish Community Development Centre**
http://www.scdc.org.uk/what/co-production-scotland/co-production-useful-resources/
This page hosts useful reports, publications, toolkits and links relating to the practice of co-production.

**Who is helping who? Challenging professional boundaries**
https://allinthistogetherwales.wordpress.com/2014/05/28/whos-helping-who-challenging-professional-boundaries/
This blog, on the Co-production Wales website, discusses the need to challenge traditional professional boundaries in public services.

**People powered health co-production catalogue**
http://www.nesta.org.uk/publications/co-production-catalogue
A volume of inspiring examples of collaborative public services in action are designed to help practitioners learn about co-production practice

**Mindshift: Activities for teams, innovators and change agents**
http://attic.bcpsqc.ca/
A site with resources to facilitate working with groups. It includes interactive team building activities to develop communication skills, model adaptive systems, shift culture, foster innovation, creativity and thought diversity.

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# Appendix A.

## Questions for consideration prior to co-production

These questions should be discussed and considered prior to commencing any co-production initiative to help understand if co-production is appropriate or possible in the context. These foundational questions will need to asked more than once, first by those who are initiating co-production and then again (and again) together with the co-production partners to support mutual decision-making and understanding of all aspects.

| HAVE WE DISCUSSED/WORKED OUT: | Yes/No |
|---|---|
| **Co-production with whom?**<br><br>· Why these particular participants? What expertise/experience is relevant for this work?<br>· Who is most affected by this problem/project? Who needs to be at the table, defining the problem/setting the agenda? | |
| **Why co-production?**<br><br>· Why have we opted for co-production (rather than consumer-led or another form of consumer participation)?<br>· Do all participants want to work co-productively? | |
| **Are we really doing co-production (and how will we know)?**<br><br>· If we are an organisation that mainly employs non-consumers but that wants to co-produce with consumers, what can we do to bring consumers in as early as possible to be involved in decision-making and direction setting?<br>· Are there enough consumers in the room?<br>· How can we prevent the process from being or becoming tokenistic?<br>· How can power be redistributed within the partnership? Can consumers fundamentally change the parameters of the project?<br>· How can we prioritise the needs of consumer partners (and whoever else needs to be prioritised)?<br>· Do consumers have autonomy?<br>· Is there trust? How is risk attended to? | |
| **How can our environment support co-production?**<br><br>· How can we make our first meeting feel different from usual meetings (accessing our creativity, 'breaking bread' together, choosing an unusual meeting place)?<br>· What resources do we have access to (people/expertise/dollars/infrastructure)? Are there other resources that we haven't thought about?<br>· What resources will we need to find before we go ahead (e.g. to pay for consumer expertise)?<br>· What needs to be done to support consumer leadership?<br>· Is everyone ready for co-production? How do we know? What else might need to happen?<br>· Are all partners appropriately trained, remunerated, resourced and supported? What capacity-building might be needed?<br>· Is the process trauma-informed? How will we know?<br>· Who else needs to be involved if this is to be effective/relevant? | |
| **What are we learning?**<br><br>· Is what we are doing co-production? Is another word more appropriate?<br>· Who stands to gain what in this process?<br>· Who stands to learn from this process?<br>· How can we move closer towards co-production for future work? | |

# Appendix B.

## Questions for discussion when bringing co-production partners together

These questions should be considered and discussed at the initial meeting when all partners are brought together. Like the questions in Appendix A, these questions need to asked more than once at different times throughout the initiative to support mutual decision-making and ensure the initiative continues to align with co-production principles.

| HAVE WE DISCUSSED/WORKED OUT: | Yes/No |
|---|---|
| Does everyone understand why we are here? Do we have a shared understanding of the problem/agenda and what we hope to do together? | |
| Does everyone have a solid understanding of co-production? What else might people need to support and deepen this understanding? | |
| How will we prioritise the agenda of consumer partners? | |
| How will we make decisions? | |
| How often do we need to meet, how and where? | |
| How will we communicate with each other? | |
| Are there pre-determined outcomes? How will outcomes be communicated, and to whom? | |
| Are there power dynamics, between participants or structural, that we need to attend to? | |
| Does anyone need more resources, supports or training to be able to participate fully? | |
| How we will know if we are working to co-production principles? How do we structure and allow opportunities for checking in about process? | |
| What will we do if people experience difficulties as a result their involvement? What do we need to put in place to address these difficulties? | |
| What process will be undertaken if someone leaves the group? | |
| Have we facilitated a process where all partners have been able to identify their strengths and their needs? <br><br> • For example discussion with questions such as: what strengths do you bring to this partnership? What kinds of supports might you need in this process? Are there gaps in your knowledge and skill set you would like to address? <br><br> • Another example is for each participant to develop a one page profile that addresses three questions: what do others like and admire about you? What is important to you? What is good support for you? <br><br> *(see an example template at:* www.helensandersonassociates.co.uk/person-centred-practice/one-page-profiles/one*-page-profile-templates/).* | |

# Appendix C.

## Questions for consideration prior to co-production

These questions should be discussed and considered prior to commencing any co-production initiative to help understand if co-production is appropriate or possible in the context. These foundational questions will need to asked more than once, first by those who are initiating co-production and then again (and again) together with the co-production partners to support mutual decision-making and understanding of all aspects.

| ITEM | TOPIC | PURPOSE | DESCRIPTION | TIME | SUPPORTING RESORCES |
|------|-------|---------|-------------|------|---------------------|
| 1. | Co-production partners meet | Get to know each other, build trust | This item allows the first meeting to feel different from usual meetings and creates the foundations for building trust among partners. | Depends on numbers, but longer than usual meeting introductions | Co-production icebreaker ideas (Appendix D) |
| 2. | Information about the initiative | Ensure all partners have all the relevant information | Information sharing and discussion. Include discussion on:<br>• Purpose<br>• Any parameters<br>• What has already been decided<br>• Who set the agenda<br>• Where there is flexibility. | Depends on complexity of initiative and how much has been previously been discussed and decided outside of the group. Ensure sufficient time for questions. | |
| 3. | What is co-production? | Information session on co-production to ensure all partners have the same understanding | Cover:<br>• Co-production – generally<br>• Difference in mental health context<br>• Co-production principles<br>• What might get in the way us co-producing?<br>• What will support us to co-produce? | 1 hour | Co-production: Putting principles into practice in mental health contexts |
| 4. | Power | Explore power as a group | Table and discuss the power differentials within the group and create a plan to address these. *Please note: this will need to continue to be explored throughout the co-production journey* | 1 hour | 'Power Map' and discussion points. Priviledge walk. |
| 5. | Setting foundations for how we will work | Collectively decide on processes | Discussion and agreement on:<br>• How decisions will be made<br>• What process will be undertaken if someone leaves the group?<br>• What support needs to be in place for participants?<br>• How will we check we are working to co-production principles? | Minimum 1 hour - may take longer | Questions for discussion when bringing co-production partners together (Appendix B) |

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# Appendix D.
## Ideas for icebreakers

It can be really helpful to include activities that enable participants to come to know each other outside of their professional roles – these icebreakers are included as some ideas to start with.

**Who is this?**[1]

Produce an A4 page list of things that people in the group have done. For example "I ran in the London Marathon in 2003", or "My first job was selling ice cream".

Give everyone the list, then they go around the room and ask questions to find out whose name to put beside each item.

**Aeroplanes**[1]

Ask everyone to write on a piece of A4 paper something nice they have done for someone – friend, customer etc. They also write their own name on the paper. They then fold the page into a paper airplane and fly it into the center of the room. Each person then picks up a plane and reads it out.

**Pull questions out of a hat**

Write some of the following questions on pieces of paper and put into a hat.

Each person has to pull one out and answer it.

Things to include are: What was the first poster you put up in your bedroom? When was the last time you did something for the first time? What's the most expensive thing you've ever found? What's the best piece of advice you've ever been given?

**What's in your bag?**

Participants are asked to take one thing out of their bag/pockets/folder and share with the group what they think this says about them.

**Pass the ball**

Participants stand in a circle.

They then pass an imaginary ball around the circle.

During the first round of passing the ball, each person receives the ball as it is passed to them, but then the ball can change size and weight (e.g. become very small and heavy) before it is passed to the next person.

During the second round, the "ball" can change shape into something entirely different (e.g. an animal, water, …).

1. Sourced from: www.linkedin.com/pulse/best-meeting-event-icebreakers-you-have-experienced-john-dalgarno

# Appendix E.

1. Provide group members with a copy of this map or draw it on a whiteboard.
2. Explore what it means to be powerful and powerless (and anything in between) - write some of these key themes on the map at each end.
3. Identify all of the power within the group - for example, funders, professional bodies, government departments, people with professional status etc.
4. Map the power identified in part 3 along the arrows on the template or whiteboard - wherever the group thinks they should fit. Discuss why they are mapped where they are.
5. Discuss strategies that the group could adopt to redistribute the power.
6. Agree on what the group will do and how power will be monitored.

## POWERLESS ➤◄ POWERFUL

**WHAT DOES NOT HAVING POWER MEAN/LOOK LIKE?**

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**STRATEGIES TO IDENTIFY AND MONITOR POWER:**

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**POSSIBLE STRATEGIES TO SHIFT POWER:**

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**WHAT DOES HAVING POWER MEAN/LOOK LIKE?**

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