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Editorial

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Introduction

Mental health care in England has seen many profound debates about its future philosophy and practice. These have not been debates about specific interventions and service models and how these ought to, or ought not to, fit in to local systems and practice. Rather, they offer deep challenges to how mental health and illness, experiences of these, and approaches to support and care are thought of.

A key example was that concerning the moves from very large-scale institutions to care geographically nearer to people's communities – the move of deinstitutionalization to community care. A key date in this development was a speech by the then Minister of Health, Enoch Powell, in 1961, which itself followed years of debate and pressure amongst and from professionals, people using mental health services, their families and relevant charities (Gilbert & Clark 2010).

Following decades of policy rhetoric of community care and significant shifts in practice, the reality of community care was seen by many as a failed policy. The view of failure and the prescription for the next steps was formed through a complex web of analyses, pressure from activists, and shifts in power (Gilbert et al 2010). Out of this came the National Service Framework (NSF) for Mental Health (Department of Health (DH) 1999), the NHS Plan (DH 2000) and new investment to improve community mental health care.

The work to move services to a recovery focus is another example of these profound debates about mental health care. This relates to long debates about shifting from a medicalised view of mental health problems and the best ways to support people to a social model perspective. Recovery has been called a 'transformation ideology' for mental health care, in particularly meaning a shift from paternalistic patterns of care to more inclusive ones which value people's autonomy (Le Boutillier et al 2011). Yet there continue to be debates and different understandings of recovery (Le Boutillier et al 2015), as well as a continuing need for evidence on how best to operationalize support for recovery. It continues to be a long road to move services to a recovery basis (Anthony 1993; DH 2011).

My reason for mentioning these two specific topics – the move to community care and developing recovery-oriented practice - is to show the long running nature of debate in mental health care about fundamental points of philosophy and practice. Long running in the sense of there has been a long history of such

debates, and in that individual disputes often continue over many, many years, even after policies have changed.   As the debates develop, as ideas crystalize and as evidence grows, so services and practice gradually change. With continuing debates about the right quantity of inpatient care and what quality means in acute and community mental health care, arguably we still haven't resolved what is the right shift to community care. And recovery is still a term emerging from the conceptual mists to be more clearly defined and operationalized (Leamy et al. 2011) (Le Boutillier et al. 2011).

So, how do we understand the current developments around co-production in mental health care? It is clearly part of a long running attempt to fundamentally shift the debate about mental health care, like that of community care and recovery before it. Commitment to more involvement of people who use services in aspects of individual and service care planning were evident in the NSF. What progress has been made and what does this move to more involvement and to working together with service users and carers to plan and deliver services and care mean in reality? This special edition of the journal is aimed at fostering and assisting in these debates.

What is co-production?

Co-production as concept, a critique of services and a guide for action has roots in the 1970s and connection with civil rights and social action work in the USA (Realpe & Wallace 2010). The critique in mental health was of services failing to fully acknowledge service users and their experiences in the delivery of support to them. The solution was seen to be more involvement of service users in decisions about how services operate. This is evolving in to ideas about working together to co-produce care.

One organisation, Think Local Act Personal, in its 'jargon buster', has defined co-production from the perspective of people involved in the process as:

> When you as an individual are involved as an equal partner in designing the support and services you receive. 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. (http://www.thinklocalactpersonal.org.uk/Browse/Informationandadvice/CareandSupportJargonBuster/#Co-production accessed August 1, 2015)

Co-production, then, is concerned with:

- Processes of connecting people and communication;
- Processes that are ongoing, rather than isolated events;
- Questions about knowledge – who's knowledge and what is valued and how is it evaluated and synthesized in to co-produced plans?
- Issues of power – what is the right balance of power in the various stages of the processes of co-production?

- Concern about outcomes – who defines them, who delivers them, and how is accountably for this organised?

These complex issues are yet to be very clearly defined and evidenced across the broad spectrum of mental health and social care.

A starting point would be some core principles to underpin co-production practice. Cahn (2000), writing about the use of time banks, argued that co-production is a construct and a process that entails operationalizing 4 principles, namely:

- Recognising people as assets in society, with skills, knowledge and experience to contribute and that everyone can be a builder and contributor to society;
- Valuing work differently to include as work the things that people do to make a good society including raising families, creating safe and vibrant neighbourhoods, delivering social justice and organising democracy;
- Promoting reciprocity, because it is seen as universal and necessary to good human life ('we need each other') as it builds trust, connections and mutual respect between people;
- Building social capital, because people need social as well as physical infrastructure for their well-being and this requires investing social capital in strong relationships and social networks.

Applied to care services, a key feature of this is challenging the notion that people should be passive recipients of services directed at them by professionals and organisations. Needham & Carr (2009), though, argued that at the same time co-production is empowering professional staff in front-line services to draw on their professional expertise and make decisions with the people they support.

The idea of co-production can be seen widely across health and social care in policy and the rhetoric of 'no decision about me, without me' (DH 2010 & 2012). It can also be seen in the concept of 'shared decision-making', an approach that has a developing evidence-base in terms of its potential impact (e.g. Durand et al. 2014). It has been asserted that co-production has an important role to play in delivering cost-effective services (Stevens 2008). Needham and Carr (2009) sounded a note of caution that co-production would not be able to address all of the challenges in social policy, suggesting a need for very clear definitions of and evidence for its effectiveness. Yet, the scope that co-production is said as potentially applying to continues to be widened, including to commissioning (e.g. see http://thinklocalactpersonal.org.uk/co-production-in-commissioning-tool/ (accessed August 1st 2015)) but without a very robust evidence base of strengths and limitations.

Co-production as an approach is highly flexible in terms of how it is applied. Needham & Carr (2009) write that this 'excessive elasticity' of the concept is a limitation of co-production as it can be defined in and used in so many ways. It has been discussed in terms of working with communities, smaller groups of

people, and individuals to deliver better services. The methods of co-production in each case can also be different. It is important then, in any specific discussion about co-production to be very clear about what level of community/individual is being involved, what the aims are what are the best means of achieving the desired ends in that specific context. There are likely to be more generalizable principles, methods and processes, but each experience of co-production is likely to be highly contextual.

At the level of individuals, co-production clearly greatly crosses over with personalization as an approach to working with people to make the services best suited to their individual needs, strengths and goals. It could also, potentially, be very driven by very individualistic, consumerist, and market-based perspectives. For Cahn (2000), co-production was a bridge between market and non-market economies designed to better balance society. Needham & Carr (2009) see that co-production was anathema to 1980s social policy in the UK as this context was dominated by market and managerialist approaches. These are valid points, but we ought not to expect that the language of co-production could never be coupled with market and/or managerial ideologies. As co-production is also about the assets that people contribute to the process it is not inconceivable that it could be linked with a 'rights and responsibilities' discourse, emphasizing that people receiving public services have a responsibility to contribute something. This, of course, could be applied in a regressive way. The concept and how it is coupled with other concepts and ideologies makes for a very flexible and fluid situation to understand.

At the level of engaging with communities, co-production could be related to communitarian and democratic ideals. It could be used as an approach to replace state support with expectations that communities provide more for themselves. It could be used as a rhetorical vehicle for co-opting others in to existing patterns of service delivery.

None of these linkages between co-production and ideologies and other concepts are absolutes or necessarily given, and other combinations of philosophies are possible. The risk is that the logic and philosophy underpinning any particular local approach to co-production is not made clear and that people are engaged in ostensibly the same co-production endeavours but with different ideals and expectations.

Co-production and mental health care

And what do we know about co-production in mental health care? Here I will focus on co-production at the level of the individual and direct care provision (rather than broader service planning), i.e. the service user and co-production of their own care and support arrangements, rather than engagement with communities. In short, there is not enough direct evidence about this form of co-production in practice in mental health care. There is, though, significant evidence about some closely tied concepts and key issues that are at the heart of co-production.

Clearly there is a need to consider the barriers and enablers to individual involvement in care if co-production is to happen successfully. Bee et al (2015) found, for example, that poor information exchange, such as persistent failure to give people enough information, especially with regard to medications and choices, was a major barrier to involvement in their own care planning. They also found in their review a consistency in the disappointment of service users, and carers, in their experiences of involvement. Service users placed a high value on the relational aspects with service providers of involvement and care planning, yet the experience seems to be so often driven by auditable procedures.

Bee et al. (2015:111) comment that with personalisation and user-involvement a key challenge continues to be 'in knowing how best to implement individualised care without concomitantly increasing procedural bureaucracy and risk-management strategies to an unsustainable level'. This will also be the case with the closely aligned concept of co-production. There will need to serious questions asked of organisational cultures and procedures and how they do, or do not, support any real movement towards co-production.

Another dimension to developing co-production in mental health is the attitudes of care professionals to co-production. In their study of the attitudes of consultant psychiatrists to shared decision making (another concept aligned with co-production) in antipsychotic prescribing Shepherd, Shorthouse & Gask (2014) found that many of their interviewees expressed support for the ideal of shared decision making. However, the author's also note how this varies with observations of practice and that a range of biases and structural factors are likely to make many incidents of the decision making process about prescribing antipsychotic medication less than the ideal shared one.

Significant in moves to change practice will be how practitioners and managers understand co-production, and here is another area where experience from another development is not initially encouraging if we are hoping for a speedy, system-wide transformation of care to co-production practice. Le Boutillier et al (2015) found that staff in mental health were using many definitions of recovery and recovery practice. Significantly, they also found that staff "struggled to make sense of recovery-orientated practice in the face of conflicting demands, informed by competing priorities" (op cit. p. 5). These included clinical priorities (usually informed by traditional mental health concerns such as symptomology), role priorities (how different staff saw their own roles), and business priorities (emphasizing organisation processes and financial concerns). It was not clear that these could be synthesized in to coherent recovery-oriented practice.

As organisational priorities, themselves shaped by the wider context of national policy and local system factors, influence recovery practice, and would do the same for co-production, it is imperative that all these elements align to support the quality of services and desired practice. Movements to develop a new

funding model for mental health, payment by results[1], must crucially support the kind of services and practice we desire (Clark 2011), and this includes carefully planning and evaluation of how it nurtures co-production.

This special issue of the journal

In this edition of the journal we have papers that seek to add more detail and evidence to our understanding of how co-production does and could operate more widely in mental health care and research.

Vanessa Pinfold and colleagues look at co-production between people with lived experience of mental health problems, carers and researchers in the context of researching personalization in mental health care. Involvement of people who are not traditional researchers, usually meaning academics, but who have other relevant experience to help shape and conduct research has become a mainstream view in health and social care research. The Department of Health funded National Institute for Health Research (NIHR), for example, has this wider involvement as a main policy throughout its research funding streams. The nature and degree of that involvement are variable from levels of consulting with members of the public, to levels of control sitting with members of the public (e.g. patients, service users and carers). Debates continue to range across what are the most appropriate levels of involvement, the best mechanisms for achieving these and the outcomes from that involvement. The NIHR School for Social Care Research, for example, has published a scoping paper by Beresford & Croft (2012) in which the authors argue for more user-controlled research.

Clearly there is a need for more clarity and evidence about co-production of research, and the contributions of Vanessa Pinfold and colleagues are most welcome here. They critically reflect on their experiences of a Lived Experience Advisory Panel (LEAP) as a means to co-produce (planning and operationalisation) the research project. Significantly the paper itself is a co-produced document and assessment of this experience.

Wharne examines issues of co-production from a theoretical perspective, namely phenomenology – examining what is experienced, and by whom - in the context of understanding psychosis. The discussion highlights the need to (re) think the nature of relationships between staff in mental health services and service users, and how these are fundamentally shaped by the models of mental health/illness that predominate in our societies and systems. Wharne notes that

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[1] The term payment by results (PbR) was the original one for the move to a payment model for mental health services in England based on a set of care clusters and paying services by the number of people allocated to each of these. The phrase used to define the policy development is in a little flux at the moment, also being referred to as 'mental health currencies and payment' and 'national tariff payment system' (Monitor & NHS England 2013) and the 'NHS payment system' (Monitor & NHS England 2014). As PbR is still the widely recognised phrase in mental health services I have used that term here.

understandings of psychosis that lead to issues of insight and vunerability means that relationships may be fundamentally enacted as ones of treating people with psychotic symptoms as 'children' or 'dependent', and these are not going to result in good co-production practice. By drawing on a phenomenological perspective and interviews from a research study, Wharne explores the different models or understandings of mental illness that people carry and, rather than asking which is right, asks, 'what are the consequences if one understanding is given more credence than others?' In the analysis it is clear that experiences at one moment, such as decisions to detain someone under the Mental Health Act, can have long running consequences for relationships and the potential for co-production way passed the point of that decision.

Turner examines the impact of a co-produced self-management programme on psychosocial outcomes for people living with depression. By drawing on literature about recovery in mental health, co-production and Wagner's chronic care model (1998) the team produced a co-creating health self management programme for people with depression. The programme was co-produced and is based on principles of co-production in its delivery. A range of data is discussed to examine the impact of the programme, including on patient activation, levels of anxiety and depression, health status and health related quality of life, and participants self-management skills. Significant improvements were found across the outcomes. It is not clear to what degree the co-production elements of the work contributed directly to these outcomes as the intervention is a complex package, but the observations of those involved in developing the programme were that it was likely to have been a key principle to help achieve the impact. The work is a helpful foundation for the further investigation needed to unpick this encouraging complex approach and the place of co-production in it.

Carers are an important part of good care and support for people experiencing mental health problems, yet they have often been omitted from and neglected by the work of services. In a review of the literature Eleanor Bradley and colleagues helpfully remind us of this and of the potential that carers could play in the co-production of care and support to deliver better outcomes for people. As we are at a relatively early stage in developing models of co-production, it is an opportunity to include carers in these developments now to ensure that we don't exclude a crucial part of the triangle of care. As Bradley and colleagues comment, rather than leaving carer expertise on the margins of mental health care, co-production is an opportunity to bring it in to the heart of new approaches. This, as with all other developments in co-production, needs to be underpinned with explicit research evidence, rather than us seeking to piece together a mosaic of evidence from different topics to try to reassemble them in to something resembling a clear narrative of what works, for whom and why.

Susan Fairlie provides us with a personal experience of applying co-production to improving care. This experience is very wide ranging, spanning work at local and national levels and within mental health care and in other parts of the NHS. The picture and lessons provided are the richer for this diversity. It demonstrates some of the ways in which co-production can be applied and key issues to be addressed in doing so. Moreover, it shows that very often

organisations have in place good practices in terms of engaging people and that these can and should be used as building blocks for developing more and better co-production. Developing good co-production is most likely to work best when it is a matter of evolution rather than revolution in local practice.

Conclusion

Co-production needs to be seen in mental health as part of that long-run debate about what a mental health care system should be like that I discussed in the introduction. We should not, then, expect fully formed and definitive approaches to co-production to be in full use across the whole system. Rather, as with community care and recovery, we can expect many years of discussion, policy formulation, local development, and research – not necessarily in that order, and nor necessarily as connected as they ought to be.

Co-production is the elastic concept that Needham and Carr (2009) alerted us to. Whenever it is being discussed, then, we need to ask that people are clear about how they are using it and, crucially, what other ideologies and concepts they are coupling it with. We also need to begin to be clearer about what a research and development agenda would be for co-production in mental health. Clearly better evidence that can be generalized and codified in practice guidance would be helpful. Perhaps, though, this will not be sufficient to improve practice and outcomes. As Dickinson (2014) has written in the context of understanding integration of care services, perhaps we will also need to be pay attention to the 'craft and graft' of practice. We need to give people the time and resources to develop co-production, which may also mean time to share, listen to and learn from each other's stories if they are to develop the craft. We also need to acknowledge the hard work, the graft, of changing and improving practice. The articles in this edition of the journal are a significant contribution to developing the evidence for, and acknowledging the craft and the graft of developing co-production.

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