

Analysing the Potential of a Coproduction Paradigm for Mental Wellbeing

Jonah Montgomery

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Ken Dicks

University of Wales Trinity St. David

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Whilst coproduction is a fairly new concept in the realm of person-centred care, applications of community support and collaboration within healthcare are nothing new. The idea of coproduction has been around throughout history as an inherent part of the way humans practised delivering health care service (Szescilo 2016, p155). Instead, the patient has always been a participant in shaping how health has developed. Physicians have learned from interacting through administering care and the resulting rapport that develops, either with a passive patient or an empowered one. However, the community that patients build with each other in the context of this medical management also plays a vital role in the beliefs and behaviours they develop. The potential applications of coproduction in the community have been proven to reduce the number of mentally ill patients in need of clinical interventions, allowing space to breathe within an overburdened medical system. Numerous recent studies have shown that ‘the partnership approach and method of delivering services in the community encourages service users to rely less on their service in the longer term, and also addresses some of the wider inequalities issues, such as stigma and discrimination, that can perpetuate poor mental health and lack of social cohesion’ (Slay & Stephens 2013). It is important to first clarify how coproduction is defined in mental healthcare.

Plenty of authors within academia, government, and charity have offered definitions for coproduction within their spheres of influence. Many conceptualizations utilize some combination of crucial principles around which the research or practice must be developed. Slay and Stephens (2013) identified coproduction as a ‘form of partnership’ as well as ‘an approach to service delivery and practice’. They elucidate six principles upon which their definition was built: the recognition of people as assets and partners in service; taking advantage of existing skills and providing support to utilize them; providing incentives for community members to collaborate with professionals; engagement of peer and personal networks for transferring knowledge; reconceptualizing the relationship between professionals and service users and reinventing methods of delivery; and finally cooperation with public service agencies as facilitators rather than managers (Slay and Stephens 2013, pg 3). These guidelines push us toward a healthcare system where physicians not only talk to the patients but listen equally to each

individual's input. Both provider and patient have equal authority over testing, treatment, and lifestyle changes, and the medical professional must supply adequate resources for people to make confident and informed decisions. There are also noted benefits when enacting these systems on a larger scale with community initiatives, peer support networks, and local resources. Individual autonomy, developed through empowerment in the facilitation and development process, was found to 'increase feelings of control over mental health difficulties', 'confidence and self-esteem', and relatedness through 'the establishment of peer support networks' (Slay and Stephens 2013, pg#).

When applying this paradigm to health care delivery, especially with mental health, we expect it to lead to improved self-image and function. After closely examining the most common conceptions, the New Economics Foundation (nef) developed a dynamic model to measure well-being. Three core psychological needs are fundamental to our ability to succeed and be happy, known as the self-determination theory: 'autonomy, competence, and relatedness' (Slay and Stephens 2013, pg13). Of the three, relatedness is most easily obtained through community: the company of family and friends, respect from peers, and camaraderie with coworkers and colleagues. Autonomy and competence are more dependent on mental fortitude and psychological resources, but being optimistic and having improved self-esteem can also make it easier to build relationships that fulfil a need for relatedness (Slay and Stephens 2013, pg. 13). When engaging with services intended to treat and improve mental health conditions, these programs must also consider building the individual's belief in their competence and autonomy. This can be accomplished through involvement in the entire medical process, from diagnostic evaluation to interpreting results, and further on when choosing procedures or treatments for their ailment.

Shared decision-making (SDM) is a coproduction model that highlights patient-centred care. This model prioritises the informed involvement of the service user and their chosen family when making decisions, and emphasises a strong alliance between clinician and patient where satisfaction is key (Ishii et al., 2014, cited in Bradley 2015). Bradley strengthens the argument by adding that 'Two clinical trials conducted

with service users diagnosed with schizophrenia have suggested that SDM can increase treatment knowledge (Hamann et al., 2006) and desire for greater responsibility in treatment decisions (Hamann et al., 2011 cited in Ishii et al., 2014)’. This model of communal decision-making builds on the central need for autonomy in learning about and choosing treatments, as well as competence in voicing their concerns, symptoms, and desires with a provider. This application of coproduction is effective in a clinical setting, but the amount of untreated people with mental illnesses is far greater than can be consistently managed by the limited professional providers. Family members and the community often must step in to fill this gap of care.

Despite their intimate knowledge of a patient and their individual needs, symptoms, and desires, carers are ‘rarely asked for their perspectives’ by health care professionals (Rose et al. 2004, cited in Bradley 2015). In clinical environments where patients may feel obligated to act differently or downplay needs or symptoms, families become crucial advocates and illuminate best practices in daily routine, treatment, and well-being outside of symptom reduction (Bradley 2015). This expertise can be utilized by health professionals by applying a paradigm of coproduction to the administration of mental health services. One strategy for incorporating a wider swathe of perspectives is by using mental health dialogues, introduced by Slay and Stephens (2013). This concept is expounded on by Bradley (2015), who defines them as “community forums where service users, carers, friends, mental health workers and others with an interest in mental health participate in an open dialogue”. Not only can this strategy make the patient more comfortable advocating for themselves, but brings in professional and personal aspects from those who likely have consistent contact with the service user, and possibly experience managing symptoms on an outpatient basis. Rather than relying entirely on medical professionals, families and carers can play a larger role in the maintenance of a person-centred care plan.

Different parts of the UK have historically had different approaches to long-term care. Roe and Galvin (2016) unpack the view of the Irish state, which primarily relied on home care provided by women

as they were traditionally viewed in the family by Catholic teaching. This conservative approach emphasised family and community care, with the government intervening only when necessary. Today, the state system only becomes involved after the family's limit is reached and they are unable to provide the necessary resources (Roe and Galvin, 2021, pg 106). However, it can be difficult to allocate resources to accurately fill the desires of a community, especially without local consultation. The bureaucratic nature of government often falls short of the mental health needs of its constituents due to a top-down, policy-first approach. When partnering with local community organisations, mental health outcomes can be improved by utilizing the diverse leverage, connections, and resources that churches and schools bring (Slay and Stephens, 2013, p17). By integrating government funding and influence, non-state community groups proactively reach out, rather than coaxing those needing mental health services to establish connections (Slay and Stephens, 2013, p17).

Numerous successful community programs pull from the concepts of coproduction with the community. In America, a psychiatric provider named Harry Stack Sullivan introduced a scheme called 'Peer Support' in the 1920s. He recruited young men who had personal experiences with overcoming mental health struggles to work in his Schizophrenia unit to take advantage of mutual peer-to-peer trust and encouragement (Perry 1982, cited in Hardy et al. 2019). The success of this program spread across Canadian systems and made its way to England by the 1980s (Hardy et al. 2019). While this agenda predated the sociological notion of coproduction, we can see numerous principles applied to the conceptualization of the program, such as the engagement of peer networks for disseminating knowledge of coping mechanisms and symptom management. A recent example of coproduction within healthcare is the Gateshead Sure Start program, formulated in the UK in 2001. This initiative focused on informing low-income new mothers of the advantages of breastfeeding by training local mothers to provide counselling and education over the radio (Bouvoir 2007, pg 852). Through a combination of publicity campaigns, a phone helpline, maternity ward outreach programs, and local support groups in deprived communities, Sure Start aims to create robust networks for mothers of peer-to-peer support, advice, and

information. Bouvoir (2007) attributes a large part of the success of this program to the trustworthiness of other mothers: “The greatest advantage of this peer support approach is that new mothers are much more willing to talk to other mothers who have had similar problems rather than professional midwives or health visitors” (Bouvoir 2007, pg 852). By creating a more accepting environment through similar lived experiences, it may be possible to access greater populations of underserved folks who have various reasons for clinical hesitancy.

The advantages of peer support work are heavily supported by newly emerging literature. Hardy et al. (2019) list some advantages of peer workers, such as similar lived experiences that lead to a deeper empathy and understanding of patients. Additionally, they help with building confidence in a nonclinical environment, which resists the negative stigma of medical model treatments by utilizing family and friend support and using clinical interventions only when necessary. Within Latino communities where family is a central value, ‘promotoras de salud’, or lay providers, can utilize their positions as trusted local community members to serve as a bridge between service providers and users. This deeper understanding of the needs of the population can improve both the perceived quality and cultural competence of care received (Steinman et al, 2023). Rather than queuing for months to see a clinician who may have limited time and resources to devote to each individual, peer workers can glean valuable information from an interpersonal relationship and help the patient to consolidate their questions and desires as well as become strong advocates for themselves in a clinical setting (Steinman et al, 2023). This approach toward health via collective coproduction relies heavily on the mutual support between experienced people who have overcome health problems and those who need, but have difficulties accessing, care for the same or similar issues (Szescilo 2016, p157). While the applications of these networks have seen success with smaller-scale applications, there is still a shortage of practitioners and uneven distribution of community resources that hold back the development of a truly national coproduction framework.

One field in which coproduction can revolutionize care is mental healthcare where the treatment gap delays or even discourages patients from seeking help due to the overburden on practitioners. Community approaches may focus on training non-clinical workers to deliver programs and interventions, which can offer an alternative yet still highly effective mental health care network (Steinman et al, 2023). These educational sessions can also tackle stigma against mental health care both by informing community workers about the true experience of mental illness as well as removing negative connotations of seeking therapy or intensive treatments. Additionally, building a robust network of local peer support can go so far as to address larger-scale inequities in health such as inadequate housing or lack of sufficient, healthy food (Steinman et al, 2023). Finally, a critical advantage of peer support within acute mental health services is that community schemes (e.g. the Personalisation Forum Group, Croydon SUN, Holy Cross time bank, etc.) build individual competence and autonomy, aiding in the acquisition of self-esteem, psychological resources, support networks, and local connections that all contribute to a reduction in the use of clinical services (Slay and Stephens, 2013, p11). Applying a coproduction paradigm to mental health care not only improves individual self-image but also reduces the burden on structured medical facilities and providers by creating alternatives for non-critical mental health care.

Despite the strong link between peer support networks and improved mental health outcomes in non-acute community management, there has been a delay in successfully implementing these interventions on a large scale. In Szescilo's 2016 research, it was found that within European national health policy, the UK is the only country to have introduced coproduction initiatives and incorporated peer support networks as a social policy strategy (Szescilo 2016, pg 157). Shortcomings with these strategies have been identified, and Bradley (2015) suggests that in difficult economic times, peer support may be used to substitute clinical care to cut costs. Szescilo also considers that it may be difficult to elucidate blame when health outcomes are poor due to a jointly devised strategy (Szescilo 2016, p159). Despite these risks, there are considerable advantages not only to individuals reaping the benefits of peer support and coproduction, but also to governments, researchers, legislators, and healthcare institutions

when devising future strategies for community well-being (Hardy et al 2019). In an era of ever-increasing knowledge and globalization of connection, the potential of coproduction and interpersonal empowerment within the mental health field is drastically underutilized and would greatly benefit from future research.

Sources

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