



Implementing co-production in mental health organizations

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Abstract

Purpose: The aim of this paper is to study four cases of the adoption of co-production and compare them according to the type of user involvement, contextual factors and the organizational structure.

Methodology: 30 interviews were conducted in four mental health organizations which are implementing co-production in the North of Italy. Interviews were conducted with clinicians, nurses, patients, and family members. The data collected were triangulated with further sources and official documents of organizations. The results have been compared by means of a validated international framework (IAP2) regarding the contextual factors and the level of co-production adopted.

Findings: The adoption of co-production in the four cases differs by the activities implemented and how organizations involve informal actors. It seems to be influenced by the contextual factor specific to each organization: power, professionals' opinions and leadership. Organizations whose practitioners and leaders are willing to distribute their power and value informal actors' opinions seem to facilitate the systematic involvement of users. Overall, the results highlight the importance of considering contextual factors when evaluating and describing co-production activities.

Originality: This paper contributes to describing how mental health organizations are implementing co-production. It examines the influence of contextual factors on the type of co-production adopted.

Keywords: Co-production, mental health, public health, patient engagement, context, organizational change.

Type: Research Paper

Manuscript

2 Introduction

3 Mental health is one of the priorities of many national healthcare systems of developed countries (Satinsky, et
4 al., 2018). Since 2007, mental disorders have been the second largest worldwide cause of health loss, with an
5 increasing rate of 12% (World Health Organization, 2018). Corroborating this scenario, a recent study by the
6 World Health Organization (WHO) estimates that the most common disorders reduce global productivity by 1
7 trillion US\$ each year (World Health Organization, 2017).

8 Currently, mental healthcare services are unable to cope with the increasing demand, widening the gap
9 between the necessity for further treatments and their supply. It has been estimated that between 35% and
10 50% of people affected by mental illnesses in developed countries receive no treatment and the percentage is
11 even higher in developing countries (World Health Organization, 2018). Within this context, the Action Plan
12 2013-2020, promoted by the World Health Organization (WHO), provides some guidelines in regard to mental
13 health issues. The most innovative suggestion is to develop “comprehensive community-based mental health
14 and social care services” that include formal and informal actors, such as families and non-governmental
15 organizations. This network aims at improving patients’ well-being, adopting a recovery-based approach that
16 enables patients to play an active role in their recovery journey and to co-produce their care by collaborating
17 with all the other clinical and informal actors (World Health Organization, 2013). Community-based services
18 increase the number of resources available in the care pathway, supporting mental health services’ providers
19 in addressing patients’ demand.

20 In accordance with this trend, the UK, Canada, Australia and other Western countries have put in place policies
21 that promote the adoption of co-production (Palmer, et al., 2018). Similarly, recent Italian National Healthcare
22 Plans have promoted the involvement of patients, caregivers and non-profit organizations in healthcare
23 pathways (Fogolino, et al., 2015). The 2011-2013 Italian Plan states that professionals should inform patients
24 about their health condition. Professionals should inquire as to the needs and preferences about the recovery
25 path of patients (Ministero della Salute, 2011) in order to improve the coordination of stakeholders’ efforts and
26 the overall outcome (Ministero della Salute, 2006). Moreover, the 2014-2018 Italian Plan highlights the
27 importance of engaging patients with mental health problems (Ministero della Salute, 2014).

1 *Co-production as a method for engaging stakeholders*

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5 2 Co-production is a method by which professionals, patients, caregivers and other informal actors (e.g.
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7 3 volunteers) collaborate and make decisions about the design, management, delivery and evaluation (Osborne,
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9 4 et al., 2016) of specific healthcare processes (Sorrentino, et al., 2016). The term 'co-production' was coined
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11 5 by Elinor Ostrom in the late 1970s (Realpe and Wallace, 2010) and its relevance has increased significantly
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13 6 in the past 20 years (Ramon, 2018). Co-production can be applied at different levels according to the kind of
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15 7 decisions that have been made. It can take place at three levels: "macro level", when co-production is applied
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17 8 to define policies collaborating with national or regional governments; "meso level", when applied at
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19 9 organizational level by involving professionals and board directors; and "micro level", when it is applied to
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21 10 decisions about the recovery journey and treatment for the single patient with that patient's clinician (Lyngsø,
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23 11 et al., 2016; Palumbo, 2016; Vennik, et al., 2015).

24
25 12 In the past decade, co-production approaches have been increasingly adopted in the healthcare sector,
26
27 13 especially in regard to chronic or long-term care (Realpe and Wallace, 2010). The benefits of involving
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29 14 stakeholders in the planning and delivery of care have been proved by various positive outcomes at both
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31 15 individual and organizational level (Mulliez, et al., 2018). The involvement of patients impacts positively on
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33 16 their health and wellbeing (Agha, et al., 2018; Gillard, et al., 2016; Bee, et al., 2015), patients' satisfaction
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35 17 (Burns, et al., 2014) and patient/professionals' relationships (Bovaird, 2007), the quality of services
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37 18 (Henderson, et al., 2004), and it reduces readmission rates, stigma and prejudices (Thorncroft and Tansella,
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39 19 2005).

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41 20 Despite the benefits of co-production, its implementation remains complex and occasional (Kirkegaard and
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43 21 Andersen, 2018; Lambert and Carr, 2018; Palmer, et al., 2018; Vaggemose, et al., 2018; Stomski and
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45 22 Morrison, 2017; Gillard, et al., 2016). It depends closely on contextual factors that shape and limit its
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47 23 implementation, so that it is impossible to identify a 'one-size-fits-all' solution; however, the influence of these
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49 24 factors is neither studied nor clear in the current literature (Sorrentino, et al., 2018).

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51 25 Among the several contextual factors reported in the literature, power, professionals' opinion and leadership
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53 26 have been widely debated.

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56 27 The first contextual factor concerns a challenging implication of co-production that entails the redistribution of
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58 28 power among clinicians, patients and other informal actors (Lambert & Carr , 2018). Professionals must
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60 29 radically review their relationship with users and carers, modifying the traditional power dynamics (Peter &

Schulz, 2018). Roles, partnerships, resources, outcomes and risks of mental health organizations have to be reshaped (Lambert & Carr, 2018). Professionals should facilitate users in their recovery rather than deliver treatments based on their own opinions. The current 'model of communication' between professionals and users should be modified to ensure the active contributions of service users (Ramon, 2018). This cultural shift is not straightforward to implement. Professionals usually obstruct the change of their professional status (Roper, et al., 2018) because they are unwilling to put themselves at the same level as users. Thus, the aversion of professionals towards co-production may dramatically reduce its adoption.

The second contextual factor concerns the value that professionals give to patients' opinions. According to co-production principles, patients and carers are resources crucial for the enhancement of service quality because they are 'experts by experience' (Gordon & O'Brien, 2018; Fox, et al., 2018). Despite the importance of patients' knowledge, professionals may not value it. They do not usually trust patients and carers' capacities (Mulliez, et al., 2018) because they view themselves as being in charge of steering patients' recovery (Roper, et al., 2018). They tend to classify users into a single 'patients' category unable or unwilling to be involved in the research (Lambert & Carr, 2018).

The third factor refers to the need for strong leadership in implementing co-production successfully. According to the literature, the adoption of co-production requires a radical change of the organizations' culture that modifies their traditional top-down structure (Palumbo et al., 2018; Gordon & O'Brien, 2018). To address this cultural shift, organizations have to spend time and effort on forcing staff to distribute their power and value users' contributions. In this scenario, a strong leadership is a fundamental driver of changes. Good leaders can encourage their staff to be trained in and adopt co-production, enabling the concrete implementation of a new vision (Mulliez, et al., 2018). An ongoing supervision ensures the change of professionals' behaviour over time (Ebrahim, et al., 2016). Instead, the lack of decision-makers and leaders' support limits the adoption of co-production (Sorrentino, et al., 2018). Thus, the attitude of leaders towards co-production may be a driver of its adoption.

Study objectives

This study aims to describe how mental health organizations translate co-production into everyday activities. Specifically, the paper contributes to research in this field by analysing how contextual factors can tailor the adoption of co-production in four mental health organizations in Italy.

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56 2 **Method**
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8 3 To increase the external validity of results and robust conclusions, we opted for a multiple case study research
9 4 design. (Yin, 2003). We decided to adopt an interpretative paradigm because the results would enable us to
10 5 observe four approaches of co-production and to frame and contextualize them in relation to their specific
11 6 contextual factors. There is no “one-size-fits-all” solution (Bovaird, et al., 2019) able to generalize the adoption
12 7 of co-production.

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18 8 **Setting**
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21 9 The target of investigation were Italian mental health organizations adopting co-production. Although the Italian
22 10 government has promoted the involvement of new stakeholders for years, especially in the mental health
23 11 sector (Ministero della Salute, 2014), the adoption of co-production is still occasional and disorganized. On the
24 12 one hand, Italian guidelines for the implementation of co-production are not clearly and univocally stated,
25 13 generating several differences among organizations. On the other hand, local contextual factors shape the
26 14 adoption of co-production, revealing differences in its implementation. Thus, Italy seems to be an interesting
27 15 area of investigation because it enables us to study the adoption of co-production and to investigate the
28 16 influence of the context.

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37 17 **Data collection**
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39 18 At present, identifying organizations adopting co-production is challenging due to the scant implementation
40 19 (Mulliez, et al., 2018) and clear understanding of this method (Norris, et al., 2017). For this reason,
41 20 organizations were selected among those participating in a conference connected to a research programme
42 21 about co-production implementation, which took place in Milan. They were contacted via e-mail by a member
43 22 of the research team. This sampling process was suitable because the objective of the research was to conduct
44 23 a general, but in-depth, analysis of Italian mental health organizations. Moreover, as these organizations were
45 24 actively participating in a co-production conference discussing cases and events, they certainly had some
46 25 knowledge about patient involvement and were motivated to implement it.

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51 26 Thirty interviews were conducted in four Italian mental health organizations between June and July 2017.
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3 1 All interviews took place at mental health organizations' offices, and they lasted 30 to 60 minutes each. To
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5 2 ensure that all relevant issues were discussed during interviews, the interviewers prepared some predefined
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7 3 questions that were chosen in line with the research objectives. The questions investigated:

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- 9 4 • The role and experience of the interviewees;
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- 11 5 • The type of activities adopted by mental health organizations to put co-production in place;
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- 13 6 • The contextual factors that enable or limit co-production's adoption;
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- 15 7 • The interviewees' points of view on patients' involvement and co-production.
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18 8 They were slightly modified according to the role of the interviewees: professionals, patients and caregivers or
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20 9 volunteers. The same researcher conducted all interviews, which were recorded (825 minutes in total) and
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22 10 transcribed verbatim. Public documents concerning the mental health organizations interviewed (annual
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24 11 reports, organizational charts, websites, leaflets) were analysed in order to increase confidence in the results
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26 12 and triangulate information (Yin, 2009).
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31 14 ****please, place TABLE 1 here****
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36 16 Case 4 had adopted co-production for more than three years, while other cases had just started to do so. The
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38 17 sample comprised 12 interviews with professionals (psychiatrists, psychologists, nurses and educators) and
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40 18 18 with non-professionals (patients, relatives and volunteers) involved in co-production activities. The
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42 19 involvement of people with different roles made it possible to check for any incongruences among groups and
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44 20 any peculiarity of each specific group.
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46 21 *Data analysis*

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49 22 The analysis of the cases had three aims: mapping co-production initiatives, studying the contextual factors
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51 23 and the level of co-production of each mental health organization. These three lenses of analysis enabled
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53 24 description and comparison of co-production implementation by the four mental health organizations.
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55 25 To address the first purpose, the interview transcripts were screened to collect and list all initiatives about co-
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57 26 production mentioned by interviewees. Activities were then clustered in categories that coincided with the
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59 27 levels of the "International Association for Public Participation" (IAP2) framework. IAP2 is a well-known
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1 framework of public involvement composed of five levels: 'inform', 'consult', 'involve', 'collaborate' and
2 'empower' (<https://www.iap2.org.au>) (International Association for Public Participation, 2014). The choice of
3 the level was made according to the original definitions given by the IAP2 itself and examples provided by
4 Burns et al. in 2014 (Burns, et al., 2014). The transcript screening, initiatives identification and clustering
5 phases were executed twice to prevent any missing data or errors. The author, who had not been involved in
6 the data analysis, checked the final classification, ensuring the completeness and correctness of results. In
7 the first level, patients are informed about their illness to make them aware of the diagnosis and treatments.
8 During the second level, patients are consulted to collect their feedbacks and preferences, while in the third
9 phase patients are involved through decisional processes. In the fourth phase patients and clinicians
10 collaborate as partners, having the same influence in identifying problems and proposing alternatives. The fifth
11 and final level assigns the power to patients, enabling them to make decisions by themselves.

12 Furthermore, the analysis was enriched with a second path that collected information about three contextual
13 factors: power dynamics, professionals' opinions and leadership. These factors were chosen because they
14 are recurrent in the literature and have different features in each case, making the comparison interesting and
15 relevant. Based on the literature findings, the interviews were screened to collect relevant information for each
16 factor.

17 Finally, the last lens of analysis investigates the influence of co-production's adoption on the organizational
18 structure. Stakeholders not 'in' the organization, such as patients and caregivers, can be involved differently
19 according to the level of co-production. Health organizations may involve stakeholders within their structure or
20 be partners with external organizations of patients and caregivers. The former approach has been called "high-
21 level co-production" because it requires the restructuring of the current top-down structure (Mulliez, et al.,
22 2018). Stakeholders are involved in the existing organization, making their involvement easier and more
23 systematic. Instead, the latter approach, termed "low-level co-production", allows mental health organizations
24 to decide on which decisions should involve stakeholders. Patients or caregivers' organizations are outside
25 the mental health ones, so that mental health organizations are not forced to collaborate with them.

1 Results

2 This section describes the adoption of co-production by mental health organizations. It focuses on the
3 initiatives implemented and the level of co-production implemented. Moreover, it examines the influence of
4 contextual factors on the adoption of co-production in each case.

5 *Activities*

6 The following section summarizes the most relevant and interesting activities reported in the appendix.

7 Cases propose diverse activities with which to inform patients, caregivers, professionals and the local
8 community. Information is shared during clinical visits, courses and events. Professionals are usually the
9 organizers of informative activities, except for self-organized courses of case 4, where caregivers inform other
10 caregivers. Each actor is informed for a specific purpose. Patients and caregivers are instructed about mental
11 illnesses and all their implications in order to face and manage them more effectively. Professionals are trained
12 in the principles of co-production in order to incentivize its correct adoption. The community is informed about
13 mental illnesses to reduce stigma and to attract people in need to go to the centre.

14 ***Educator in Case 2:*** *“This mental health organization would like to sensitize the local community*
15 *about mental health and attract the interest of people that are not sure about coming to our center.”*

16 In the consulting phase, patients and caregivers can express their preferences and feedbacks. Informal actors
17 can share their opinions during the Questions & Answers sessions of courses and conferences. Moreover,
18 professionals in cases 1, 2 and 3 consult informal actors in defining course topics. They ask patients or
19 caregivers about a set of themes that they would like to discuss and organize meetings accordingly. In all
20 cases, informal actors can share their preferences.

21 The involvement level allows patients and caregivers to participate in decision-making processes and to
22 influence decisions. Cases 3 and 4 involve patients in defining patients' roles and everyday tasks within the
23 organization, such as cleaning, gardening or cooking, but only professionals take the final decisions.

24 ***Psychiatrist in Case 4:*** *“The network is invited to collaborate on problems or relevant issues that are*
25 *important to discuss together. My objective [as a psychiatrist] is to understand the network's interests*
26 *and objectives and to collaborate with actors for their achievement”*

27 During the collaboration phase, professionals collaborate in partnership with informal actors at the same level
28 of power. Actors involved in this phase are asked to take decisions regarding various issues: for instance,
29 everyday activities of centres, leisure and extra activities and patient treatments. Decisions regarding the
30 organization and its activities are usually taken by a mixed group composed of patients, caregivers, volunteers
31 and professionals. Instead, choices related to patients' treatments are established by professionals and

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1 patients during clinical visits. Some collaborations are limited in time because they are related to a specific
 2 projects or events, such as creative workshops, conferences and specific courses (case 1 and 3). Other
 3 collaborations are accomplished periodically as meetings to decide organizations' activities and patients'
 4 treatments (case 2 and 4).

Patient in Case 4: *"FareAssieme meetings have been organized and implemented by patients, professionals and the whole community for three years".*

Patient in Case 3: *"We organized a small English course last year, but after some lessons we stopped."*

10 Although the literature states that patients, once they have achieved recovery, are able to manage and live
 11 with their symptoms by gaining control over their illness (McGregor, et al., 2014), only centre 4 enabled patients
 12 to be empowered and to take decision on their own. Patients in case 4, who were identified as "expert patients",
 13 could coordinate clinical teams and groups of patients.

Patient in Case 4: *"Firstly, the expert patient meets the patient and create his own idea about the patient's personality related to: work, routines, family, childhood. Then, he shares his idea with the group. All the group's members should be at the same level and the expert patient is in charge of maintaining this equality."*

19 They belong to a group composed of educators and psychiatrists that collaborate to support complex patients.
 20 They not only participate in the group but also coordinate it, ensuring effective communication and
 21 management between professionals and patients. Similarly, expert patients can coordinate a group of other
 22 patients, who participate in the mental health organization's everyday activities.

Patient in Case 4: *"I am helping other patients because it is just amazing. I am coming down the stairs to leave the centre, when patients greet me and say: "Bye, see you tomorrow". This is really satisfying; it is my drug."*

27 This role has positive effects on patients, creating empathic and mutual relationships with peers, and on expert
 28 patients, increasing their self-esteem.

30 **Contextual factors**

31 To facilitate the analysis of the adoption of co-production, this section investigates three relevant contextual
 32 factors: power, professionals' opinion and leadership.

33 The first contextual factor concerns the willingness of professionals to distribute their power with users and
 34 carers. Among all cases, only case 4 was willing to distribute its power to informal stakeholders (as patients,
 35 carers and volunteers) involving them in the organization. Stakeholders collaborated and took decisions in

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3 1 partnership with professionals, sharing roles and responsibilities related to the organization's everyday
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5 2 activities.

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7 3 **Professional in case 4:** "I [as a psychiatrist] have decided to give up part of my power to create a
8 4 new organization where all stakeholders are represented. [...] and can share their ideas, opinions and
9 5 projects."

10 6
11 7 Instead, cases 1, 2 and 3 preferred to maintain existing professionals' roles and power dynamics of the
12 8 organizations. Informal actors were not part of the organizations and did not have any role. Professionals were
13 9 free to choose the type of interaction with informal users according to their willingness to create partnerships.
14 10 Although professionals are not forced to collaborate with informal actors, some of them seemed interested in
15 11 participating in non-clinical organizations' activities. There are some differences within this scenario. While
16 12 professionals in cases 2 and 3 shared roles and responsibilities with informal actors in non-clinical
17 13 organizations, professionals in case 1 were more reluctant to collaborate at the same level with non-clinical
18 14 actors.

19 15 **Caregiver in case 1:** Professionals have never involved us. There was a barrier and a discrepancy
20 16 between professionals and us. The collaboration with professionals was neither fast nor simple.

21 17 The second contextual factor concerns professionals' opinions about patients' knowledge and skills.
22 18 Professionals in case 4 seemed to value users' opinions and recognize their knowledge as 'experts by
23 19 experience' not only for decisions relating to the centre but also for treatment options.

24 20
25 21 **Patient in case 4:** "I am involved in all activities. Professionals have trusted in my capabilities, giving
26 22 new opportunities that have increased my self-esteem"

27 23
28 24 Instead, some professionals in the other cases were still struggling to value users' opinions and capabilities.

29 25 **Educator in case 3:** "In general, professionals do not think that users' knowledge might be a resource
30 26 for themselves and for other patients".

31 27 While the majority of professionals in case 2 supported patients' preferences and knowledge, many
32 28 professionals in cases 1 and 3 were still sceptical.

33 29
34 30 **Professional in case 1:** "Co-production activities seem to be linked to some specific professionals.
35 31 The majority of professionals are not interested. I feel alone."

36 32
37 33 The third contextual factor relates to the leadership of mental health organizations. Case 4's leaders had a
38 34 clear vision of co-production, spreading it through several training courses for professionals.

39 35 **Professional in case 4:** Co-production is a working approach that we, as an organization, are trying
40 36 to adopt as much as possible. It is effective, efficient, as well as demanding.

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3 1 They had also modified the traditional model of communication, enhancing the collaboration of stakeholders
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5 2 in all activities. Leaders in case 2 had just started to adopt a similar approach as they were trying to modify the
6
7 3 traditional view of the organization by implementing courses for professionals.

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9 4 **Psychiatrist in case 2:** *"I completely support co-production but we do not adopt it for all activities. As
10 5 the director of the organization, I would like to go in this direction because I think co-production is the
11 6 approach that ensures the highest quality".*
12 7

13 8 Differently, leaders in cases 1 and 3 did not support co-production and were not willing to change the traditional
14
15 9 view and model of communication accordingly.

16
17 10 **Caregiver in case 1:** *"we have several issues for interacting with psychiatrists, who are very sheltered
18 11 in their role. Psychiatrists are still thinking that all their beliefs are correct".*
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21 13 Indeed, the current exchange of opinions between caregivers and professionals takes place within non-clinical
22
23 14 organizations and the number of initiatives in the collaborating phase are few and limited in time.

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25 15 The next Figure sums up the incidence of the three contextual factors for each mental health organization
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29 18 ***please, place FIGURE 1 here***
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32 20 *Level of adoption*

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34 21 Each of the four organizations provides different services, as shown in *Table 2*. Daily Centre¹ and
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36 22 Psychological Social Centre provide care to outpatients, while High Intensive Care and Hospital Centre treat
37
38 23 acute cases. Organizations of patients, caregivers and other non-profit entities perform activities that
39
40 24 complement the traditional clinical care.

41
42 25 As displayed by *Table 2*, organizations adopt both high and low levels of co-production. The low co-production
43
44 26 level leaves existing stakeholders free to decide the number and types of partnership with external
45
46 27 stakeholders. They do not involve external actors in the organizational structure of the service. Thus, they are
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48 28 solely responsible for taking final decisions. Instead, the high co-production level obliges existing stakeholders
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50 29 to involve systematically other actors in decision-making processes. External actors become part of boards
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52 30 and teams that take decisions about the service. According to the level of co-production, decision-making
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54 31 power can be more or less centralised.
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¹ Complete descriptions of each structure are provided in the appendix

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6 2****please, place TABLE 2 here****7
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10 4 Case 4 is the only one that had a high level of coproduction in all its services. Patients, caregivers and
11 5 community were directly involved in the governance of all services of the organization, collaborating in
12 6 partnerships with professionals. The level of power between professionals and other stakeholders was the
13 7 same, and all decisions were taken jointly. Concurrently, case 4 did not have any non-clinical organizations,
14 8 because external stakeholders (e.g. patients and caregivers) were involved within the existing clinical one.
15 9 Instead, almost all other cases had at least one non-clinical organization, and the high level of co-production
16 10 was only adopted in some non-clinical organizations.
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28 12 **Discussion**

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30 13 The results reported four examples of mental health organizations implementing co-production. They
31 14 highlighted the initiatives proposed to involve informal actors, contextual factors that were different in each
32 15 case, and the level of co-production implemented in each service.
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36 16 The implementation of co-production is influenced by staff's willingness to distribute their power (Lambert &
37 17 Carr, 2018), professionals' trust in patients and carers' capacities (Mulliez, et al., 2018) and a strong leadership
38 18 (Ebrahim, et al., 2016). On comparing the four organizations, it seems that the presence of these contextual
39 19 factors is associated with high levels of co-production and of informal actors' involvement.
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****please, place TABLE 4 here****

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53 25 According to Table 4, case 4 is the organization with the highest level of involvement and co-production. This
54 26 well-established adoption of co-production is related to high support by leaders and professionals and the
55 27 distribution of power. To achieve this scenario, leaders in case 4 stated a new vision and communication model
56 28 that enabled the large majority of professionals to adopt co-production in many organizational activities.
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1 Instead, cases 1 and 3, which had the lowest level of involvement and co-production, did not have the support
2 of leaders and professionals and distributed power. Leaders in cases 1 and 3 had neither changed their
3 organizations' culture and structure nor involved users constantly in time. They preferred to adopt co-
4 production for few activities limited in time, leaving professionals free to decide whenever to adopt it. Thus, co-
5 production was an 'add-on' to the existing activities. Finally, case 2 seems to be a third approach in between
6 the previous two groups. Although it adopted a low-level of co-production within its organization, the number
7 of activities undertaken were numerous and long-lasting. This scenario is confirmed by the contextual factors.
8 While the support of leaders and professionals for co-production is medium-high, power is not distributed within
9 the organization. Professionals and leaders in case 2 seemed to value co-production principles but were not
10 willing to modify the internal organizational structure or their roles and responsibilities. Thus, case 2 had
11 succeeded in modifying the existing culture, influencing professionals' perceptions against co-production but
12 it had not changed the structure and roles of the organization.

13 Our research shows that some cases prefer to adopt a low level of co-production and others prefer a high
14 level. Both approaches are equally important and valid. Some organizations may prefer low-level co-production
15 for two reasons. Firstly, leaders and professionals consider co-production as an 'add-on' to the current
16 activities. They would like to be free to adopt or not adopt co-production activities. The choice of adopting co-
17 production is usually related to a specific project or initiative limited in time. Secondly, organizations do not
18 have to modify drastically the distribution of power and organizational structure, reducing time and effort for
19 this rearrangement. Other organizations may prefer to adopt high-level co-production, although they must
20 change their existing culture, activities and structure. One possible reason is that the adoption of co-production
21 over time generates co-production benefits, such as patient satisfaction, patient/professional relationships, and
22 service quality. However, it may be a third option that tries to exploit co-production's benefits without drastically
23 changing power dynamics and the organizational structure. Case 2 adopted several co-production initiatives
24 over time that may yield higher benefits of co-production for organizations that adopt it for few specific activities.
25 Meanwhile, it does not involve non-clinical actors in the organizational structure that enable it to limit
26 organizational and power changes.

27 28 **Conclusion and future research**

29 Co-production may be one possible solution to the current challenges of mental health systems, because of
30 its capacity to ensure interdisciplinary approaches, points of view and knowledge (Nyström, et al., 2018). This

1
2
3 1 paper has sought to describe the implementation of co-production in four mental health organizations, giving
4
5 2 practical examples of co-production activities and studying the influence of the context.
6

7
8 3 According to the results, the cases adopted different levels of co-production as well as different numbers and
9
10 4 types of co-production initiatives. The differences in the adoption of co-production may be influenced by the
11
12 5 specific context of each case. To study the influence of the context, four mental health organizations were
13
14 6 analysed and compared by considering the influence of three contextual factors: power dynamics,
15
16 7 professionals' opinions and leadership. Depending on the contextual factors in each case, organizations may
17
18 8 be in favour of adopting co-production as a 'add-on' to centres' everyday activities, as an essential part of all
19
20 9 organizational decision-making processes or as a trade-off between these two extremes. The lack of a "one-
21
22 10 size-fits-all" solution that works in all circumstances (Bovaird, et al., 2019) entails the necessity to describe,
23
24 11 evaluate and measure the co-production activities by looking at the influence of the contextual factors.

25
26 12 Future studies should examine the effectiveness and efficiency of co-production in mental health organizations
27
28 13 in relation to their structure. Not only is the most appropriate structure for the adoption of co-production rarely
29
30 14 studied (Stott and Johnson, 2018), but also the evidence of co-production's positive effect on the quality of
31
32 15 treatment and care is not clear (Jo and Nabatchi, 2018; Lea, et al., 2016). Proof of an additional value of co-
33
34 16 production in comparison to the traditional delivery of care is a key driver for convincing clinicians, mental
35
36 17 health organizations (Boardman and Shepherd, 2011) and policy-makers (Pagatpatan and Ward, 2017) to
37
38 18 adopt it. More validated tools will be needed to evaluate patient participation (Manafò, et al., 2018), especially
39
40 19 in the mental health sector.

41
42 20 This study has limitations. Although it is a multiple case study that makes it possible to collect and compare
43
44 21 different approaches and results, the context of all cases is very specific. All the centres analysed were located
45
46 22 in Italy and had similar structure, culture and policies. Thus, the present study is only a first step of research
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48 23 in this field.
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1 2 3 1 **Dictionary**

4
5
6 2 *Psychological Social Centre* is the most important mental health structure. It organizes the acceptance of
7
8 3 patients and collaborates with local entities in order to improve the health of patients. It coordinates different
9
10 4 activities: ambulatory, psychotherapeutic, rehabilitative and socialization ones.

11
12 5 *High intensive Care* is a community that assures assistance 24 hours a day for high intensity rehabilitation. It
13
14 6 offers a specific, personalized and short-term recovery path for each patient (maximum 18 months). It
15
16 7 welcomes patients at a sub-acute stage of their illness.

17
18
19 8 *Daily Centre* is a place where people can learn various capabilities, such as: interacting with other actors,
20
21 9 taking care of themselves and managing their routine.

22
23 10 *Hospital centre* welcomes patients in crisis, who should be controlled 24 hours. Patients stay in this structure
24
25 11 for a medium-short period and then are moved to others (Regione Lombardia, 2018).

26
27
28 12 *Patients' organizations* are supporting groups of patients who have completely recovered and decide to
29
30 13 support other patients.

31
32 14 *Caregivers' organizations* are voluntary organizations of caregivers that support other caregivers throughout
33
34 15 patients' recovery.

35
36
37 16 *Voluntary organizations* are responsible for all entertainment activities such as weekend trips, cinema, dinners
38
39 17 and sport's meetings.

40 41 18 **Appendix**

42
43
44 19 Table 3 groups initiatives of each case according to the level of involvement of patients and caregivers. The
45
46 20 levels of involvement are reported in the rows from the basic one (*Inform*) to the higher (*Empower*), while the
47
48 21 columns display all the mental health organizations studied.

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53 23 ****please, place TABLE 3 here****

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Enablers for implementing co-production's implementation production in mental health organizations

Abstract

Purpose: The aim of this paper is to facilitate effective implementation study four cases of co-production in mental health organizations, reflecting on the appropriateness of the adoption of co-production and compare them according to the type of user involvement, contextual factors and the organizational structures and on the selection of co-production initiatives. Structure.

Methodology: 30 interviews were conducted in four mental health organizations, which are implementing co-production in the North of Italy. Interviews were performed conducted with clinicians, nurse nurses, patients, and family members. Data The data collected were triangulated with further information and other related sources. Results and official documents of organizations. The results have been compared through by means of a validated international framework (IAP2-) regarding the contextual factors and the level of co-production adopted.

Findings: In the cases, stakeholders are involved through several activities that engage them in different ways. Only one case promotes the complete involvement of both patients and caregivers. This case differs from the others also because it involves patients, caregivers and volunteers directly within clinical organizations. Overall, the cases highlight the necessity to decide the best level of co-production according to their ability to manage complexity, their possibility to collect public incentives and their inclination to modify the traditional top-down culture.

Findings: The adoption of co-production in the four cases differs by the activities implemented and how organizations involve informal actors. It seems to be influenced by the contextual factor specific to each organization: power, professionals' opinions and leadership. Organizations whose practitioners and leaders are willing to distribute their power and value informal actors' opinions seem to facilitate the systematic involvement of users. Overall, the results highlight the importance of considering contextual factors when evaluating and describing co-production activities.

Originality: This paper aims contributes to contribute in guiding describing how mental health organizations in the implementation of are implementing co-production. It gives insight examines the influence of contextual factors on how to modify the internal structure of mental health centres for ensuring the systematic adoption type of co-production. Moreover, it lists possible practical activities for engaging patients according to their health status. adopted.

Keywords: Co-production, mental health, public health, patient engagement, organizational structure context, organizational change.

Type: Research Paper

Manuscript

2 Introduction

3 Mental health is one of the priorities of many ~~National Healthcare Systems~~ national healthcare systems of
4 developed countries (Satinsky, et al., 2018). Since 2007, mental disorders have been the second largest
5 worldwide cause of health loss, with an increasing rate of 12% (World Health Organization, 2018). ~~In 2017,~~
6 ~~the most popular disorders were depression and anxiety, with respectively 4,52% and 3,76% of the total Years~~
7 ~~Lived with Disability of worldwide population (Healthdata, 2018). To corroborate these results~~ Corroborating
8 this scenario, a recent study ~~of~~ by the World Health Organization (WHO) estimates that ~~depression and~~
9 ~~anxiety~~ the most common disorders reduce ~~the~~ global productivity ~~of~~ by 1 trillion US\$ each year (World Health
10 Organization, 2017) ~~and the number of people affected by these diseases had raised in the last ten years~~
11 ~~(Healthdata, 2018).~~

12 Currently, mental healthcare services are ~~not able~~ unable to ~~face~~ cope with the increasing demand,
13 ~~raising~~ widening the gap between the necessity for further treatments and their supply. It has been estimated
14 that ~~a percentage~~ between 35% and 50% of people affected by mental ~~diseases~~ illnesses in developed
15 countries receive no treatment and the percentage is even higher in developing countries (World Health
16 Organization, 2018). Within this context, the Action Plan 2013-2020, promoted by ~~the~~ the World Health
17 Organization (WHO), provides some guidelines ~~for facing~~ in regard to mental health issues. The most
18 innovative suggestion is to develop ~~a~~ “comprehensive community-based mental health and social care
19 services” that include formal and informal actors, such as families and non-governmental organizations. This
20 network aims at improving patients’ well-being, ~~following~~ adopting a recovery-based approach that enables
21 patients to play an active role ~~on~~ in their recovery journey and to co-produce their care ~~by~~ by collaborating with all
22 the other clinical and informal actors (World Health Organization, 2013). Community-based services increase
23 the number of resources available ~~resources~~ in the care pathway ~~of care~~, supporting mental health services’
24 providers in addressing patients’ demand.

25 ~~According to~~ In accordance with this trend, ~~the~~ the UK, Canada, Australia and other Western countries have put in
26 place policies that promote the adoption of co-production (Palmer, et al., 2018). Similarly, recent Italian
27 National Healthcare Plans have promoted the involvement of patients, caregivers and ~~non~~ non-profit
28 organizations ~~within~~ in healthcare pathways (Fogliano, et al., 2015). The 2011-2013 Italian Plan states that
29 professionals should inform patients ~~on~~ about their health condition, ~~asking their~~ Professionals should inquire

1 ~~as to the~~ needs and preferences about the recovery path ~~of patients~~ (Ministero della Salute, 2011~~);~~ in order
 2
 3
 4
 5 2 to improve the coordination of stakeholders' ~~effortefforts~~ and the overall outcome (Ministero della Salute,
 6
 7 3 2006). Moreover, the 2014-2018 ~~Italian~~ Plan highlights the importance of engaging patients with mental health
 8
 9 4 problems (Ministero della Salute, 2014).

5 *Co-production as a method for engaging stakeholders*

6 Co-production is a method ~~throughby~~ which professionals, patients, caregivers and other informal actors (e.g.
 7
 8 volunteers) collaborate and make decisions about the design, management, delivery and evaluation ~~phases~~
 9
 10 (Osborne, et al., 2016) of specific healthcare processes (Sorrentino, et al., 2016). The term 'co-production'
 11
 12 was coined by Elinor Ostrom in the late 1970s (Realpe and Wallace~~,~~ 2010) and its relevance has increased
 13
 14 significantly in the ~~lastpast~~ 20 years (Ramon, 2018). Co-production can be applied at different levels according
 15
 16 to the kind of decisions that have been made. It can take place at three ~~levellevels~~: "macro level", when co-
 17
 18 production is applied to define policies collaborating with national or regional governments; "meso level", when
 19
 20 applied at organizational level by involving professionals and board ~~of~~ directors; and "micro level", when it is
 21
 22 applied to decisions about the recovery journey and treatment for ~~the~~ single patient with ~~that~~ patient's clinician
 23
 24 (Lyngsø, et al., 2016; Palumbo, 2016; Vennik, et al., 2015).

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 34 16 In the ~~lastpast~~ decade, co-production approaches have been increasingly adopted in the healthcare sector,
 35
 36 especially ~~onin regard to~~ chronic or long-term care (Realpe and Wallace, 2010). The benefits of involving
 37
 38 stakeholders in the planning and delivery of care have been proved ~~throughby~~ various positive outcomes ~~at~~
 39
 40 both ~~at~~ individual and organizational level (Mulliez, et al., 2018). The ~~engagementinvolvement~~ of patients
 41
 42 impacts positively on their health and wellbeing (Agha, et al., 2018; ~~Gillard, et al., 2016;~~ Bee, et al., 2015),
 43
 44 patients' satisfaction (Burns, et al., 2014) and patient-~~/~~professionals' relationships (Bovaird, 2007). ~~Through~~
 45
 46 ~~co-production, patients), the quality of services (Henderson, et al., 2004), and caregivers become able to take~~
 47
 48 ~~informed decisions. Thus, healthcare organizations should opt for a set of initiatives that enhance the adoption~~
 49
 50 ~~of co-production by patientsit reduces readmission rates, stigma and caregivers prejudices (Thorncroft and~~
 51
 52 ~~Tansella, 2005).~~

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1 and mental consequences of a critical health episode). They perceive themselves as behaviourally unequipped
2 to face their new health status. Thus, they are unable to take an active position in their recovery, but they can
3 be engaged in simple activities or preliminary actions toward recovery. Then, patients become more conscious
4 of their condition and aware of their health status, but they are unconfident in being autonomous and ask
5 constantly feedbacks from professionals and clinicians. Finally, patients accept their new health status and
6 would like to achieve a “new normality” (Barello and Graffigna, 2015), being able to be proactive in decision-
7 making. This last phase consents the application of co-production at its maximum level, where patients,
8 caregivers, professionals and other informal actors collaborate in partnership sharing decisional power,
9 enhancing democracy and effectiveness of organizational outcomes (Norris, et al., 2017).

10 Several studies show that co-production enhances services' quality (Henderson, et al., 2004), clinical
11 outcomes (Gillard, et al., 2016) and reduces readmission's rates, population's stigma and prejudices
12 (Thornicroft and Tansella, 2005). However, there is some hesitation towards patients' capacities to take part
13 in decision-making processes (Mulliez, et al., 2018) and difficulties in implementing co-production approaches
14 in real practice. Therefore, the implementation of co-production remains complex and occasional (Kirkegaard
15 and Andersen, 2018; Lambert and Carr, 2018; Palmer, et al., 2018; Vaggemose, et al., 2018; Stomski and
16 Morrison, 2017; Gillard, et al., 2016). In order to enhance the adoption of co-production, researches have
17 proved the necessity of modify the traditional top-down structure of organizations (Mulliez, et al., 2018;
18 Palumbo, et al., 2018) but further studies are needed to identify effective alternatives (Stott and Johnson,
19 2018; Kleinhans, 2017). It depends closely on contextual factors that shape and limit its implementation, so
20 that it is impossible to identify a 'one-size-fits-all' solution; however, the influence of these factors is neither
21 studied nor clear in the current literature (Sorrentino, et al., 2018).

22 This is Among the case also in Italy, where several contextual factors reported in the adoption literature, power,
23 professionals' opinion and leadership have been widely debated.

24 The first contextual factor concerns a challenging implication of co-production that entails the redistribution of
25 power among clinicians, patients and other informal actors (Lambert & Carr, 2018). Professionals must
26 radically review their relationship with users and carers, modifying the traditional power dynamics (Peter &
27 Schulz, 2018). Roles, partnerships, resources, outcomes and risks of mental health organizations have to be
28 reshaped (Lambert & Carr, 2018). Professionals should facilitate users in their recovery rather than deliver
29 treatments based on their own opinions. The current 'model of communication' between professionals and
30 users should be modified to ensure the active contributions of service users (Ramon, 2018). This cultural shift

1
2
3 1 is not straightforward to implement. Professionals usually obstruct the change of their professional status
4
5 2 (Roper, et al., 2018) because they are unwilling to put themselves at the same level as users. Thus, the
6
7 3 aversion of professionals towards co-production may dramatically reduce its adoption.
8

9
10 4 The second contextual factor concerns the value that professionals give to patients' opinions. According to co-
11
12 5 production principles, patients and carers are resources crucial for the enhancement of service quality because
13
14 6 they are 'experts by experience' (Gordon & O'Brien, 2018; Fox, et al., 2018). Despite the importance of
15
16 7 patients' knowledge, professionals may not value it. They do not usually trust patients and carers' capacities
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18 8 (Mulliez, et al., 2018) because they view themselves as being in charge of steering patients' recovery (Roper,
19
20 9 et al., 2018). They tend to classify users into a single 'patients' category unable or unwilling to be involved in
21
22 10 the research (Lambert & Carr, 2018).

23
24 11 The third factor refers to the need for strong leadership in implementing co-production successfully. According
25
26 12 to the literature, the adoption of co-production requires a radical change of the organizations' culture that
27
28 13 modifies their traditional top-down structure (Palumbo et al., 2018; Gordon & O'Brien, 2018). To address this
29
30 14 cultural shift, organizations have to spend time and effort on forcing staff to distribute their power and value
31
32 15 users' contributions. In this scenario, a strong leadership is a fundamental driver of changes. Good leaders
33
34 16 can encourage their staff to be trained in and adopt co-production, enabling the concrete implementation of a
35
36 17 new vision (Mulliez, et al., 2018). An ongoing supervision ensures the change of professionals' behaviour over
37
38 18 time (Ebrahim, et al., 2016). Instead, the lack of decision-makers and leaders' support limits the adoption of
39
40 19 co-production (Sorrentino, et al., 2018). Thus, the attitude of leaders towards co-production may be a driver of
41
42 20 its adoption.

21 22 **Study objectives**

23
24 23 This study aims to describe how mental health organizations translate co-production into everyday activities.
25
26 24 Specifically, the paper contributes to research in this field by analysing how contextual factors can tailor the
27
28 25 adoption of co-production in four mental health organizations in Italy.
29
30 26

Method

To increase the external validity of results and robust conclusions, we opted for a multiple case study research design. (Yin, 2003). ~~still occasional and disorganized, despite Government~~ We decided to adopt an interpretative paradigm because the results would enable us to observe four approaches of co-production and to frame and contextualize them in relation to their specific contextual factors. There is no “one-size-fits-all” solution (Bovaird, et al., 2019) able to generalize the adoption of co-production.

Setting

The target of investigation were Italian mental health organizations adopting co-production. Although the Italian government has promoted the involvement of new stakeholders for years, especially in the mental health sector (Ministero della Salute, 2014). ~~The involvement of patients and stakeholders requires the healthcare system to rearrange the traditional organizations’ structure (Palumbo, et al., 2018) but the new optimal structure is not explicated, increasing dramatically the difficulty for mental health organizations to put conceptual guidelines into practice),~~ the adoption of co-production is still occasional and disorganized. On the one hand, Italian guidelines for the implementation of co-production are not clearly and univocally stated, generating several differences among organizations. On the other hand, local contextual factors shape the adoption of co-production, revealing differences in its implementation. Thus, Italy seems to be an interesting area of investigation because it enables us to study the adoption of co-production and to investigate the influence of the context.

Study objectives

~~This study aims to facilitate effective implementation of co-production in mental health organizations, understanding its impact on organizational structures and giving practical examples of co-production activities. Specifically, this paper integrates the research in this field by analysing practical initiatives of co-production in four mental health organizations in Italy and studying its effects on the related organizational structures. Finally, it highlights enablers that enhance the adoption of co-production, giving tips for ensuring implementation in the long-term.~~

Method

Due to the exploratory nature of the research and to the limited evidence about organizational impact and enablers of co-production, we opted for multiple case study research design Data collection

At present (Yin, 2003).

~~To date~~, identifying organizations adopting co-production is challenging due to the ~~limit of scant~~ implementation (Mulliez, et al., 2018) and clear understanding of this method (Norris, et al., 2017). For this reason, organizations were selected ~~between among~~ those participating ~~to in~~ a conference connected to a research ~~program programme~~ about co-production implementation, which took place in Milan, ~~and~~. ~~They were~~ contacted via e-mail by a member of the research team. This sampling process ~~is was~~ suitable, ~~as because~~ the objective of the research ~~is was~~ to ~~gain conduct~~ a general, but in-depth, analysis of Italian mental health organizations. Moreover, as these organizations were actively participating ~~to in~~ a co-production conference, ~~by~~ discussing cases and events, ~~ensures that they have certainly had~~ some knowledge about patient involvement and ~~are were~~ motivated to implement it.

Thirty interviews ~~were conducted~~ in four Italian mental health organizations ~~have been conducted~~ between June and July 2017.

All interviews took place at mental health organizations' offices, and ~~they~~ lasted 30 to 60 minutes each. ~~To ensure that all relevant issues were discussed during interviews, the interviewers prepared some predefined questions that were chosen in line with the research objectives. The questions investigated:~~

- ~~The role and experience of the interviewees;~~
- ~~The type of activities adopted by mental health organizations to put co-production in place;~~
- ~~The contextual factors that enable or limit co-production's adoption;~~
- ~~The interviewees' points of view on patients' involvement and co-production.~~

~~They were slightly modified according to the role of the interviewees: professionals, patients and caregivers or volunteers. The same researcher conducted all interviews, which were recorded (825 minutes in total) and transcribed verbatim. Public documents concerning the mental health organizations interviewed (annual reports, organizational charts, websites, leaflets) were analysed in order to increase confidence in the results and triangulate information (Yin, 2009).~~

please, place TABLE 1 here

Case 4 had adopted co-production for more than three years, while other cases had just started to do so. The sample counts comprised 12 interviews with professionals (psychiatrists, psychologists, nurse psychiatrists, psychologists, nurses and educators) and 18 with non-professionals (patients, relatives and volunteers) involved in co-production activities. The involvement of people with different roles gives the opportunity made it possible to check for any incongruences between among groups and any peculiarity of each specific group. Thus, results has been gather together according cases and roles, highlighting differences between mental health organizations and interviewees' roles.

To ensure that all relevant issues were discussed during interviews, the interviewers prepared some predefined questions about:

the role and experience Data analysis

- 1.—The analysis of the interviewees in the mental health organization;
- 2.—cases had three aims: mapping co-production initiatives, studying the contextual factors and the level of co-production put in place within the organization;
- 3.—barriers and enablers of co-production that interviewees had found in their experience;
- 4.—interviewees' point each mental health organization. These three lenses of views on patients' involvement and analysis enabled description and comparison of co-production;

The same researcher conducted all interviews, in order to prevent any possible incongruence in data collection. Interviews were recorded (825 minutes records in total) and transcribed verbatim. Public documents about interviewed implementation by the four mental health organizations (annual reports, organizational charts, websites, leaflets) have been analysed in order to increase the confidence of results and triangulate information (Yin, 2009).

Data collected in each case have been analysed according to the To address the first purpose, the interview transcripts were screened to collect and list all initiatives about co-production mentioned by interviewees. Activities were then clustered in categories that coincided with the levels of the "International Association for Public Participation" (IAP2) framework (IAP2), one of the most famous model is a well-known framework of public involvement proposed by the literature. IAP2 proposes composed of five levels of engagement: 'inform',

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3 1 'consult', 'involve', 'collaborate' and 'empower' (Burns, et al., 2014).<https://www.iap2.org.au>) (International
4 Association for Public Participation, 2014). The first phase informs patients about their disease, in order to let
5 2 them understand the diagnosis, treatments and future obstacles choice of recovery, moving back to their
6 3 routine activities. The second phase starts to involve patients asking them the level was made according to
7 4 the original definitions given by the IAP2 itself and examples provided by Burns et al. in 2014 (Burns, et al.,
8 5 2014). The transcript screening, initiatives identification and clustering phases were executed twice to prevent
9 6 any missing data or errors. The author, who had not been involved in the data analysis, checked the final
10 7 classification, ensuring the completeness and correctness of results. In the first level, patients are informed
11 8 about their illness to make them aware of the diagnosis and treatments. During the second level, patients are
12 9 consulted to collect their feedbacks and preferences, while in the third phase involves patients throughout are
13 10 involved through decisional processes, in order to guarantee the constant collection of patients' opinions. In
14 11 the fourth phase patients and clinicians collaborate as partners at the same level, having the same influence
15 12 in identifying problems and proposing alternatives. Finally, the last The fifth phase and final level assigns the
16 13 power to patients, enabling them to make decisions by themselves (IAP2, 2014). As
17 14
18 15 Furthermore, the analysis was enriched with a second path that collected information about three contextual
19 16 factors: power dynamics, professionals' opinions and leadership. These factors were chosen because they
20 17 are recurrent in the literature and have different features in each case, making the comparison interesting and
21 18 relevant. Based on the literature findings, the interviews were screened to collect relevant information for each
22 19 factor.
23 20
24 21 Finally, the last lens of analysis investigates the influence of co-production's adoption on the organizational
25 22 structure. Stakeholders not 'in' the organization, such, this qualitative evaluation framework emerged as
26 23 particularly effective to classify the results and measure the organizations' attitude and capacity of involving
27 24 patients and caregivers, can be involved differently according to the level of co-production. Health
28 25 organizations may involve stakeholders within their structure or be partners with external organizations of
29 26 patients and caregivers. The former approach has been called "high-level co-production" because it requires
30 27 the restructuring of the current top-down structure (Mulliez, et al., 2018). Stakeholders are involved in the
31 28 existing organization, making their involvement easier and more systematic. Instead, the latter approach,
32 29 termed "low-level co-production", allows mental health organizations to decide on which decisions should
33 30 involve stakeholders. Patients or caregivers' organizations are outside the mental health ones, so that mental
34 health organizations are not forced to collaborate with them.

Results

This section describes the ~~level of~~ adoption of co-production by mental health organizations, ~~focusing. It focuses~~ on the ~~relative impact on organizations' structures. initiatives implemented and the level of co-~~ production implemented. Moreover, it ~~report~~ examines the influence of contextual factors on the adoption of co-production in each case.

Activities

The following section summarizes the most relevant and interesting activities performed for engaging reported in the appendix.

Cases propose diverse activities with which to inform patients and, caregivers, professionals and the local community. Information is shared during clinical visits, courses and events. Professionals are usually the organizers of informative activities, except for self-organized courses of case 4, where caregivers inform other caregivers. Each actor is informed for a specific purpose. Patients and caregivers are instructed about mental illnesses and all their implications in order to face and manage them more effectively. Professionals are trained in the principles of co-production in order to incentivize its correct adoption. The community is informed about mental illnesses to reduce stigma and to attract people in need to go to the centre.

Educator in Case 2: *"This mental health organization would like to sensitize the local community about mental health and attract the interest of people that are not sure about coming to our center."*

In the consulting phase, patients and caregivers can express their preferences and feedbacks. Informal actors can share their opinions during the Questions & Answers sessions of courses and conferences. Moreover, professionals in cases 1, 2 and 3 consult informal actors in defining course topics. They ask patients or caregivers about a set of themes that they would like to discuss and organize meetings accordingly. In all cases, informal actors can share their preferences.

The involvement level allows patients and caregivers to participate in decision-making processes and to influence decisions. Cases 3 and 4 involve patients in defining patients' roles and everyday tasks within the organization, such as cleaning, gardening or cooking, but only professionals take the final decisions.

Psychiatrist in Case 4: *"The network is invited to collaborate on problems or relevant issues that are important to discuss together. My objective [as a psychiatrist] is to understand the network's interests and objectives and to collaborate with actors for their achievement"*

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3 1 During the collaboration phase, professionals collaborate in partnership with informal actors at the same level
4
5 2 of power. Actors involved in this phase are asked to take decisions regarding various issues: for instance,
6
7 3 everyday activities of centres, leisure and extra activities and patient treatments. Decisions regarding the
8
9 4 organization and its activities are usually taken by a mixed group composed of patients, caregivers, volunteers
10
11 5 and professionals. Instead, choices related to patients' treatments are established by professionals and
12
13 6 patients during clinical visits. Some collaborations are limited in time because they are related to a specific
14
15 7 projects or events, such as creative workshops, conferences and specific courses (case 1 and 3). Other
16
17 8 collaborations are accomplished periodically as meetings to decide organizations' activities and patients'
18
19 9 treatments (case 2 and 4).

20
21 10 ***Patient in Case 4: "FareAssieme meetings have been organized and implemented by patients,***
22 11 ***professionals and the whole community for three years".***

23 12 ***Patient in Case 3: "We organized a small English course last year, but after some lessons we***
24 13 ***stopped."***

25 14
26 15 Although the literature states that patients, once they have achieved recovery, are able to manage and live
27
28 16 with their symptoms by gaining control over their illness (McGregor, et al., 2014), only centre 4 enabled patients
29
30 17 to be empowered and to take decision on their own. Patients in case 4, who were identified as "expert patients",
31
32 18 could coordinate clinical teams and groups of patients.

33 19 ***Patient in Case 4: "Firstly, the expert patient meets the patient and create his own idea about the***
34 20 ***patient's personality related to: work, routines, family, childhood. Then, he shares his idea with the***
35 21 ***group. All the group's members should be at the same level and the expert patient is in charge of***
36 22 ***maintaining this equality."***

37 23
38
39 24 They belong to a group composed of educators and psychiatrists that collaborate to support complex patients.
40
41 25 They not only participate in the group but also coordinate it, ensuring effective communication and
42
43 26 management between professionals and patients. Similarly, expert patients can coordinate a group of other
44
45 27 patients, who participate in the mental health organization's everyday activities.

46
47 28 ***Patient in Case 4: "I am helping other patients because it is just amazing. I am coming down the stairs***
48 29 ***to leave the centre, when patients greet me and say: "Bye, see you tomorrow". This is really satisfying:***
49 30 ***it is my drug."***

50 31
51
52 32 This role has positive effects on patients, creating empathic and mutual relationships with peers, and on expert
53
54 33 patients, increasing their self-esteem.

55 34
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57 35 ***Contextual factors***
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1
2
3 1 To facilitate the analysis of the adoption of co-production, this section investigates three relevant contextual
4 2 factors: power, professionals' opinion and leadership.

6 3 The first contextual factor concerns the willingness of professionals to distribute their power with users and
7 4 carers. Among all cases, only case 4 was willing to distribute its power to informal stakeholders (as patients,
8 5 carers and volunteers) involving them in the organization. Stakeholders collaborated and took decisions in
9 6 partnership with professionals, sharing roles and responsibilities related to the organization's everyday
10 7 activities.

11 8 ***Professional in case 4: "I [as a psychiatrist] have decided to give up part of my power to create a***
12 9 ***new organization where all stakeholders are represented. [...] and can share their ideas, opinions and***
13 10 ***projects."***

14 11 Instead, cases 1, 2 and 3 preferred to maintain existing professionals' roles and power dynamics of the
15 12 organizations. Informal actors were not part of the organizations and did not have any role. Professionals were
16 13 free to choose the type of interaction with informal users according to their willingness to create partnerships.
17 14 Although professionals are not forced to collaborate with informal actors, some of them seemed interested in
18 15 participating in non-clinical organizations' activities. There are some differences within this scenario. While
19 16 professionals in cases 2 and 3 shared roles and responsibilities with informal actors in non-clinical
20 17 organizations, professionals in case 1 were more reluctant to collaborate at the same level with non-clinical
21 18 actors.

22 19 ***Caregiver in case 1: Professionals have never involved us. There was a barrier and a discrepancy***
23 20 ***between professionals and us. The collaboration with professionals was neither fast nor simple.***

24 21 The second contextual factor concerns professionals' opinions about patients' knowledge and skills.
25 22 Professionals in case 4 seemed to value users' opinions and recognize their knowledge as 'experts by
26 23 experience' not only for decisions relating to the centre but also for treatment options.

27 24 ***Patient in case 4: "I am involved in all activities. Professionals have trusted in my capabilities, giving***
28 25 ***new opportunities that have increased my self-esteem"***

29 26 Instead, some professionals in the other cases were still struggling to value users' opinions and capabilities.

30 27 ***Educator in case 3: "In general, professionals do not think that users' knowledge might be a resource***
31 28 ***for themselves and for other patients"***

32 29 While the majority of professionals in case 2 supported patients' preferences and knowledge, many
33 30 professionals in cases 1 and 3 were still sceptical.

34 31 ***Professional in case 1: "Co-production activities seem to be linked to some specific professionals.***
35 32 ***The majority of professionals are not interested. I feel alone."***
36 33
37 34

1
2
3 1 The third contextual factor relates to the leadership of mental health organizations. Case 4's leaders had a
4
5 2 clear vision of co-production, spreading it through several training courses for professionals.

6
7 3 ***Professional in case 4: Co-production is a working approach that we, as an organization, are trying***
8 4 ***to adopt as much as possible. It is effective, efficient, as well as demanding.***

9 5
10 6 They had also modified the traditional model of communication, enhancing the collaboration of stakeholders
11 7 in all activities. Leaders in case 2 had just started to adopt a similar approach as they were trying to modify the
12 8 traditional view of the organization by implementing courses for professionals.

13 9 ***Psychiatrist in case 2: "I completely support co-production but we do not adopt it for all activities. As***
14 10 ***the director of the organization, I would like to go in this direction because I think co-production is the***
15 11 ***approach that ensures the highest quality".***

16 12
17 13 Differently, leaders in cases 1 and 3 did not support co-production and were not willing to change the traditional
18 14 view and model of communication accordingly.

19 15 ***Caregiver in case 1: "we have several issues for interacting with psychiatrists, who are very sheltered***
20 16 ***in their role. Psychiatrists are still thinking that all their beliefs are correct".***

21 17
22 18 Indeed, the current exchange of opinions between caregivers and professionals takes place within non-clinical
23 19 organizations and the number of initiatives in the collaborating phase are few and limited in time.

24 20 The next Figure sums up the incidence of the three contextual factors for each mental health organization

25 21
26 22
27 23 ***please, place FIGURE 1 here***

28 24 29 25 ***Level of co-production's adoption***

30 26 Each of the four organizations provides different services, as ~~displayed~~shown in Table 2. Daily Centre¹ and
31 27 Psychological Social Centre provide care to outpatients, while High Intensive Care and Hospital Centre
32 28 ~~follow~~treat acute ~~one~~cases. Organizations of patients, caregivers and other ~~no~~non-profit entities perform
33 29 activities that complement the traditional clinical care.

34 30 ~~New stakeholders, such as patients and caregivers, can be involved differently according to the level of co-~~
35 31 ~~production adopted. HealthAs displayed by Table 2, organizations might involve stakeholders within their~~
36 32 ~~structure or partner with external organizations of patients and caregivers. The fist approach requires the~~

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¹ Complete ~~description~~descriptions of each structure are ~~reported~~provided in the appendix

1 restructuring of the current top-down structure (Mulliez, et al., 2018), because all decisions about the
 2 organization or patients' health should be established by professionals in partnership with patients and
 3 caregivers. This approach is reported as "high-level of co-production" in Table 2. Instead, the second
 4 approach, defined as "low-level of co-production", allows mental health organizations to decide on which
 5 decisions involving stakeholders. Patients or caregivers' organizations are outside of the mental health ones,
 6 so mental health organizations are not forced to collaborate with them.

7 Organizations adopt co-production at different both high and low levels using both approaches, according to
 8 their wiliness to change the existing top-down structure of co-production. The low co-production level leaves
 9 existing stakeholders free to decide the number of type and types of partnership with external stakeholders;.
 10 They do not involve external actors in the organizational structure of the service. Thus, they are the only one
 11 in charge to take solely responsible for taking final decisions. Instead, the high co-production level
 12 obligates obliges existing stakeholders to involve systematically other actors in taking decisions decision-
 13 making processes. External actors become part of boards and teams that take decisions about the service.
 14 According to the type, the decisional level of co-production, decision-making power can be more or less
 15 centralised.

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 17 ****please, place TABLE 2 here****
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19 Case 4 is the only one that hashad a high level of coproduction in all its services. Patients, caregivers and
 20 community are were directly involved in the governance of all services of the organization, collaborating in
 21 partnership partnerships with professionals. The level of power between professionals and other stakeholders
 22 is was the same, and all decisions are made together were taken jointly. Concurrently, case 4 does did not have
 23 any non-clinical organizations, because external stakeholders (e.g. patients and caregivers) are were involved
 24 within the existing clinical one. Instead, almost all other cases have had at least one non-clinical organization,
 25 and the high level of co-production is was only adopted in some non-clinical organizations. Indeed, patients
 26 and other informal actors usually support the involvement of professionals in non-clinical organizations'
 27 activities, implementing a high level of co-production. While professionals do not involve external stakeholders;
 28 they accept to collaborate with other actors but only outside their clinical organizations.

1 **Activities**

2 Table 3 groups initiatives of each case according to the level of involvement of patients and caregivers. The
 3 levels of engagement are reported on the rows from the basic one (*Inform*) to the higher (*Empower*), while the
 4 columns display all mental health organizations studied.

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 7 ~~***please, place TABLE 3 here***~~

8
 9 The following paragraph explains the most relevant and interesting activities summarized in Table 3.

10 Cases propose different activities for **informing** patients, caregivers and the local community about
 11 mental diseases and related topics. During the clinical visit (1) professionals inform patients about their
 12 disease, treatments' options and centre's activities through leaflets and oral explanation. (2) Patients
 13 and caregivers receive technical information about illness through weekly courses, which last one to
 14 nine months, involving 5 to 11 participants. Each course discusses a specific mental disease, aiming
 15 at informing patients on drugs and symptoms caused by their mental condition. During the course,
 16 participants meet different actors: psychiatrists, educators, operators or other experts that teach them
 17 using written materials, such as slides or books, and oral information, as frontal lessons. In case 4 (3)
 18 patients and caregivers organize courses for peers with the coordination of a psychiatric. Self-
 19 organized courses are not focused on technical knowledge but they aim at sharing experiential
 20 knowledge gained through direct experience. Case 4 and 2 organize also (3) conferences and events
 21 open to the whole community, for increasing awareness and reducing prejudices and stigma. While
 22 conferences have a clear scheduling of experts and patients' interventions, events do not have a
 23 structured agenda.

24 In the consulting phase patients and caregivers have the opportunity to express their preferences and
 25 feedbacks. During the Q&A sessions of each course and conference, (1) patients and caregivers have the
 26 opportunity to discuss and exchange opinions with peers and teachers. (2) In case 1, 2 and 3 meetings'
 27 organizers periodically ask patients or caregivers a set of topics that they would like to discuss and organize
 28 evening meetings accordingly. Experts preside over the first introductory part of the meeting. Then, patients
 29 and caregivers can make questions and share their feeling and concerns with the audience.

30 Patients and caregivers are **involved** in some decision-making process, having the opportunity to influence
 31 decisions. (1) Patients, willing to work for the centre, take an appointment with professionals to discuss
 32 activities and the objectives of this role. Then, clinicians assign patients to a specific activity, as front-office
 33 collaborator, coordinator of Daily Centre and supervisor of Psychological Social Care. The activity's
 34 assignation is made according to patients' capacity of gaining responsibility and preferences, which are
 35 highlighted during the meeting. (2) Similarly, professionals of the psychological social centre of case 3 organize

1 each morning a meeting with patients and assign to them a daily tasks (e.g. cleaning toilette, gardening,
2 cooking) based on their preferences. Finally, (3) Case 4 involves patients and other informal actors in the
3 development of new projects, in order to enrich the research with different point of views and increase the
4 effectiveness of the outcome.

5 The **collaboration** phase has been used in different initiatives and processes of the mental health
6 organization, which recognizes the relevance of patients and caregivers' experiential knowledge. (1) Case 2
7 and 4 have established FareAssieme: a group of patients, caregivers and professionals, aiming at reducing
8 prejudices related to mental illness through the ideation of events and conferences open to the whole
9 community. Patients and caregivers have the same level of power and influence of professionals in all
10 decisions taken by the group. (2) Case 4 adopts a mix committee composed of patients, caregivers, volunteers,
11 educators, nurses and clinicians who makes decisions regarding the centre and its improvement. The
12 committee is very democratic because non-professionals members are elected and the total number of their
13 votes is higher than 50%. The aim of this group is to propose new ideas for the improvement of users' condition.
14 (3) Likewise case 2 has created AppuntaMenti: a mixed team that meets once a month for identifying and
15 solving issues and inefficiencies of the centre. (4) FareFamiglia is a group of patients, parents and
16 professionals belonging to the centre that aims at informing caregivers about mental illness through a set of
17 meetings. The group define a list of possible interesting topics for the meetings. Then, the list is sent to all
18 participants, who select the most interesting ones. The group collects all filled lists and starts organizing
19 meetings on the most required topics. The peculiarity of this initiative is the fact that the group itself has decided
20 the methodology for implementing the project. (5) In order to enable collaborating activities within patient-
21 professional relationship, case 2 has promoted the use of PTI tool that supports psychiatrics in deciding with
22 patients the more suitable treatments and recovery activities. Then, the decisions are reported in a formal
23 document signed by both patients and psychiatrics.

24 Once patients have completed their recovery, they are able to "overcome or manage disabling symptoms by
25 gaining mastery over the illness" (McGregor, et al., 2014). Only centre 4 enables patients to be **empowered**
26 and to take an active part in their life through several initiative. (1) Once patients have completed their recovery
27 and have participate to a set of courses, they are identified as "expert patients" and have the possibility to take
28 part to a group composed of educators and psychiatrics that coordinate and share opinions about specific
29 complex patients. The introduction of the expert patient in the team enriches traditional clinical knowledge with
30 the experiential knowledge that no one of professionals have. Giving the importance of the expert patient in

1 the team (Roberts, et al., 2011), he/she is the coordinator of the group, ensuring an effective communication
2 and management of patients' recovery. (2) Expert patients, working in the Daily Centre, are asked to organize
3 activities for a group of patients every morning. They enable the recovery process because their role increases
4 hope in other patients and the creation of empathic relationships. This role benefits also expert patients
5 increasing their self-esteem.

6 Case 4 is the only one that has reported initiatives in the empowering level, which gives patients responsibilities
7 and decisional power. As such, case 4 ensures a complete involvement of patients, managing and leading all
8 activities within the existing clinical structures.

9 Discussion

10 The results reported four examples of mental health organizations implementing co-production. They
11 highlighted the initiatives proposed to involve informal actors, contextual factors that were different in each
12 case, and the level of co-production implemented in each service.

13 The implementation of co-production is influenced by staff's willingness to distribute their power (Lambert &
14 Carr, 2018), professionals' trust in patients and carers' capacities (Mulliez, et al., 2018) and a strong leadership
15 (Ebrahim, et al., 2016). On comparing the four organizations, it seems that the presence of these contextual
16 factors is associated with high levels of co-production and of informal actors' involvement.

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19 ***please, place TABLE The analysed mental health organizations have confirmed several enablers for the
20 systematic involvement of stakeholders. Case 1 and 3 have recognized the importance of organizing training
21 courses for patients and case 4 also for caregiver and professionals, in order to give them all needed
22 competences and knowledge for taking part to co-production activities (Vaggemose, et al., 2018; Freeman
23 here***

24
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26 According to Table 4, case 4 is the organization with the highest level of involvement and co-production. This
27 well-established adoption of co-production is related to high support by leaders and professionals and the
28 distribution of power. To achieve this scenario, leaders in case 4 stated a new vision and communication model
29 that enabled the large majority of professionals to adopt co-production in many organizational activities.

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2
3 1 Instead, cases 1 and 3, which had the lowest level of involvement and co-production, did not have the support
4 of leaders and professionals and distributed power. Leaders in cases 1 and 3 had neither changed their
5 organizations' culture and structure nor involved users constantly in time. They preferred to adopt co-
6 production for few activities limited in time, leaving professionals free to decide whenever to adopt it. Thus, co-
7 production was an 'add-on' to the existing activities. Finally, case 2 seems to be a third approach in between
8 the previous two groups. Although it adopted a low-level of co-production within its organization, the number
9 of activities undertaken were numerous and long-lasting. This scenario is confirmed by the contextual factors.
10 While the support of leaders and professionals for co-production is medium-high, power is not distributed within
11 the organization. Professionals and leaders in case 2 seemed to value co-production principles but were not
12 willing to modify the internal organizational structure or their roles and responsibilities. Thus, case 2 had
13 succeeded in modifying the existing culture, influencing professionals' perceptions against co-production but
14 it had not changed the structure and roles of the organization.

15 Our research shows that some cases prefer to adopt a low level of co-production and others prefer a high
16 level. Both approaches are equally important and valid. Some organizations may prefer low-level co-production
17 for two reasons. Firstly, leaders and professionals consider co-production as an 'add-on' to the current
18 activities. They would like to be free to adopt or not adopt co-production activities. The choice of adopting co-
19 production is usually related to a specific project or initiative limited in time. Secondly, organizations do not
20 have to modify drastically the distribution of power and organizational structure, reducing time and effort for
21 this rearrangement. Other organizations may prefer to adopt high-level co-production, although they must
22 change their existing culture, activities and structure. One possible reason is that the adoption of co-production
23 over time generates co-production benefits, such as patient satisfaction, patient/professional relationships, and
24 service quality. However, it may be a third option that tries to exploit co-production's benefits without drastically
25 changing power dynamics and the organizational structure. Case 2 adopted several co-production initiatives
26 over time that may yield higher benefits of co-production for organizations that adopt it for few specific activities.
27 Meanwhile, it does not involve non-clinical actors in the organizational structure that enable it to limit
28 organizational and power changes.

29 , et al., 2016). The partnership between patients and professionals (micro level) is organized in almost all cases
30 through tools that enhance the definition of Specific, Measurable, Attainable, Realistic and Timely (SMART)
goals (Satinsky, et al., 2018) and shared project plan (Meddings, et al., 2014) regarding the recovery path of

1 patients. Instead, only Case 4 has just started to set few clear goals and a draft shared plan for formalizing the
2 adoption of co-production at meso level. Finally, all cases have created a network of mixed stakeholders
3 (McGregor, et al., 2014) within or outside the clinical organization, confirming the importance of working in
4 teams (Freeman, et al., 2016).

5 Patients and caregivers have different needs and health status, so they might be at different level of the co-
6 production process (Barello and Graffigna, 2015). Mental health organizations have to put in place a set of
7 initiatives for each level of engagement. According to the results, case 4 is the only one that ensures a complete
8 involvement of stakeholders, promoting at least one initiative for each level of engagement. It is also the only
9 case with a high co-production level in all its services. All the other cases prefer to collaborate with stakeholders
10 through external non-clinical organizations founded by patients, caregivers and volunteers. Even if the
11 literature encourages community-based services, in which clinical organizations collaborate with external
12 supporting organizations or stakeholders; this approach might have some inaccuracies. Community-based
13 services, which opt for low co-production level, tend to have significant complexity in managing interactions
14 and coordinating stakeholders. Clinical and non-clinical organizations are independent and have different
15 regulations, objectives, resources and incentive systems, rising several difficulties for effective collaborations.
16 Instead, the involvement of stakeholders in the existing clinical network reduces time and effort in decision-
17 making processes. Moreover, the possibility to collaborate with external organizations does not force clinical
18 structures to involve stakeholders in their internal structure. Professionals of clinical organizations do not have
19 to change their traditional top-down culture because they can choose when and how to collaborate with
20 external organizations. Instead, the integration of a network of different actors within the organization's
21 boundaries forces professionals to collaborate in partnership with patients and caregivers. A high-level of co-
22 production seems to ensure the constant involvement of stakeholders and reduce the complexity of
23 coordination and management of the network. However, the adoption of high co-production level in all services
24 may require a considerable initial investment in terms of resources, training courses additional facilities. Case
25 4, which has the highest level of public incentives (Conorzio per la Ricerca Economica Applicata in Sanità,
26 2018), prefers the adoption of high level of co-production; while all the other cases with lower public incentives
27 opt for the low level of co-production in clinical organization.

28 Results reveal the necessity to re-organizing activities and resources of current mental health organizations
29 (Boardman and Shepherd, 2011) that decide to adopt co-production, modifying the traditional service system
30 through the involvement of stakeholders and the transformation of top-down processes in collaborative ones

(Stott and Johnson, 2018; Ryan, 2016). The best level of co-production to adopt depends on capabilities, resources and culture of mental health organizations.

Conclusion and future research

Co-production ~~might~~ be one possible solution to the current challenges of mental health ~~system, due to~~ systems, because of its capacity to ensure interdisciplinary approaches, ~~point~~ points of ~~view~~ views and knowledge (Nyström, et al., 2018). This paper ~~aim~~ has sought to ~~facilitate~~ describe the ~~effective~~ implementation of co-production in ~~four~~ mental health organizations, ~~understanding its impact on organizational structures and~~ giving practical examples of co-production activities.

~~The studied cases have confirmed several enablers reported in the literature, highlighting and studying the influence of the importance to create a network of mixed actors, to train all stakeholders and professionals about co-production and to define clear and shared goals for enhancing the adoption of co-production both at micro and meso level. Moreover, results show that mental health centres, which decide to implement co-production, are asked to redefine their organizational structure, principles and culture (Freeman, et al., 2016; Tuurnas, 2015), using a high or low level of co-production for involving patients, caregiver and other informal actors. The best level of co-production should be chosen accordingly to the capacity of managing complexity, the availability of economic incentives and the culture of clinical organizations. Furthermore, mental health organizations should review their services in order to be able to engage patients at different health status context.~~

~~According to the results, the cases adopted different levels of co-production as well as different numbers and types of co-production initiatives. The differences in the adoption of co-production may be influenced by the specific context of each case. To study the influence of the context, four mental health organizations were analysed and compared by considering the influence of three contextual factors: power dynamics, professionals' opinions and leadership. Depending on the contextual factors in each case, organizations may be in favour of adopting co-production as a 'add-on' to centres' everyday activities, as an essential part of all organizational decision-making processes or as a trade-off between these two extremes. The lack of a "one-size-fits-all" solution that works in all circumstances (Bovaird, et al., 2019) entails the necessity to describe, evaluate and measure the co-production activities by looking at the influence of the contextual factors.~~

Future studies should ~~deepen~~ examine the effectiveness and efficiency of co-production in mental health organizations in relation to their structure. Not only ~~is~~ the most appropriate structure for the adoption of co-

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3 1 production ~~is~~ rarely studied (Stott and Johnson, 2018), but also the evidence of co-production's positive effect
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5 2 on the quality of treatment and care is not clear (Jo and Nabatchi, 2018; Lea, et al., 2016). ~~The proof~~Proof of
6
7 3 an additional value of co-production in comparison to the traditional ~~delivering~~delivery of care is a key driver
8
9 4 for convincing clinicians, mental health organizations (Boardman and Shepherd, 2011) and policy-makers
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11 5 (Pagatpatan and Ward, 2017) to adopt it. More validated tools will be needed to evaluate patient participation
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13 6 (Manafò, et al., 2018), especially in the mental health sector.

14
15 7 This study ~~contains~~has limitations. ~~Firstly, the number of cases~~Although it is ~~limited due to the shortage of~~
16
17 8 ~~Italian mental health organizations a multiple case study that are adopting co-production.~~Secondly makes it
18
19 9 possible to collect and compare different approaches and results, the context of all cases is very specific. All
20
21 10 the centres analysed ~~centres are~~were located in Italy ~~with~~and had similar structure, culture and policies. Thus,
22
23 11 the present study is just only a first ~~insight~~step of ~~future~~ research in this field.

1 Dictionary

2 *Psychological Social Centre* is the most important mental health structure. It organizes the acceptance of
3 patients and collaborates with local entities in order to improve the health of patients. It coordinates different
4 activities: ambulatory, psychotherapeutic, rehabilitative and socialization ones.

5 *High intensive Care* is a community that assures assistance 24 hours a day for high intensity rehabilitation. It
6 offers a specific, personalized and short-term recovery path for each patient (maximum 18 months). It
7 welcomes patients ~~classified as~~ a sub-acute ~~stadium~~ stage of ~~the disease~~ their illness.

8 *Daily Centre* is a place where people can learn ~~again the abilities to interact~~ various capabilities, such as:
9 interacting with other, ~~take~~ actors, taking care of themselves and ~~managemanaging~~ their routine ~~during the~~
10 daily hours.

11 *Hospital centre* welcomes patients in crisis, who should be controlled 24 hours. Patients stay in this structure
12 for a medium-short period and then are moved to others (Regione Lombardia, 2018).

13 *Patients' organizations* are ~~a~~ supporting ~~group~~ groups of patients, who have completely recovered, and decide
14 to support other patients.

15 *Caregivers' organizations* are voluntary organizations of caregivers that support other caregivers throughout
16 patients' recovery.

17 *Voluntary organizations* ~~collaborate with the mental centre~~ are responsible ~~offor~~ all entertainment activities
18 such as weekend trips, ~~going to the~~ cinema, ~~having dinner together~~ dinners and ~~doing sports~~ sport's meetings.

19 Appendix

20 Table 3 groups initiatives of each case according to the level of involvement of patients and caregivers. The
21 levels of involvement are reported in the rows from the basic one (*Inform*) to the higher (*Empower*), while the
22 columns display all the mental health organizations studied.

24 ***please, place TABLE 3 here***

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Implementing co-production in mental health organizations

Table 1

	Case 1	Case 2	Case 3	Case 4
<i>Mental health organization location</i>	Como- Lombardy	Saronno- Lombardy	Treviglio- Lombardy	Trento- Trentino Alto Adige
<i>Number of interviews</i>	-1 Nurse -2 Educators -4 Patients -2 Relatives	-1 Psychiatrist -2 Educators -1 Patient -2 Relative	-1 Psychologist -2 Educators -4 Patients -1 Volunteer	-1 Psychiatrist -2 Educators -2 Patients -2 Relatives

Table 1 Case studies' interviews

Implementing co-production in mental health organizations

Table 2

Services provided in each organization and level of co-production in decision making	Case 1	Case 2	Case 3	Case 4
<i>Daily Centre</i>	low	low	low	high
<i>Psychological Social Centre</i>	low	low	low	high
<i>High Intensive Care</i>		low	low	
<i>Hospital centre</i>	low	low		high
<i>Patients' organization</i>	low	high		
<i>Caregivers' organization</i>	high	high		
<i>Voluntary organization</i>		high	high	

Table 1 Services provided in each organization and level of co-production in decision-making

Implementing co-production in mental health organizations

Table 3

Levels of engagement	Case 1	Case 2	Case 3	Case 4
<i>Inform</i>	-Oral information during clinical visit.	-Oral information during clinical visit; -Specific disease courses; -Courses for caregivers; -Courses for professionals; -Open informing events.		-Oral information during clinical visit; -Written information during clinical visit; -Specific disease courses; -Courses for professionals (3 years ago); -Self-organized courses; -Open conferences.
<i>Consult</i>	-Evening meetings with caregivers.	-Periodical meeting with caregivers.	-Evening meetings with young patients.	-Q&A session at specific disease courses; - Q&A session at self-organized courses; - Q&A session at open conferences.
<i>Involve</i>			-Morning group meetings;	-Definition of the role of expert patients; -Patients as consultants of centre's projects.
<i>Collaborate</i>	-Evening meetings' decisional board with caregivers.	-FareAssieme committee; -AppuntaMenti; -Piano di Trattamento Individuale (PTI) tool;	-Patients' laboratories; -Patient as part of the decisional board of open conferences.	-FareAssieme committee; -Mixed governance of mental health centre; -FareFamiglia.
<i>Empower</i>				-Expert patient as leader of the clinical team; -Expert patients as professional in the daily centre.

Table 1 Activities put in place by each case organized according IAP2 framework

Implementing co-production in mental health organizations

Table 4

Comparative factors	Case 1	Case 3	Case 2	Case 4
<i>Informal actors' involvement</i>	Medium-low	Medium-low	Medium-high	High
<i>Level of co-production</i>	Low	Low	Low	High
<i>Power</i>	Low	Medium-low	Medium-low	High
<i>Valuing patients' opinions</i>	Low	Low	Medium	High
<i>Leadership</i>	Low	Low	Medium-high	High

Table 4 Comparative factors of mental health organizations

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Implementing co- production in mental health organizations

FIGURE 1

FIGURE 1

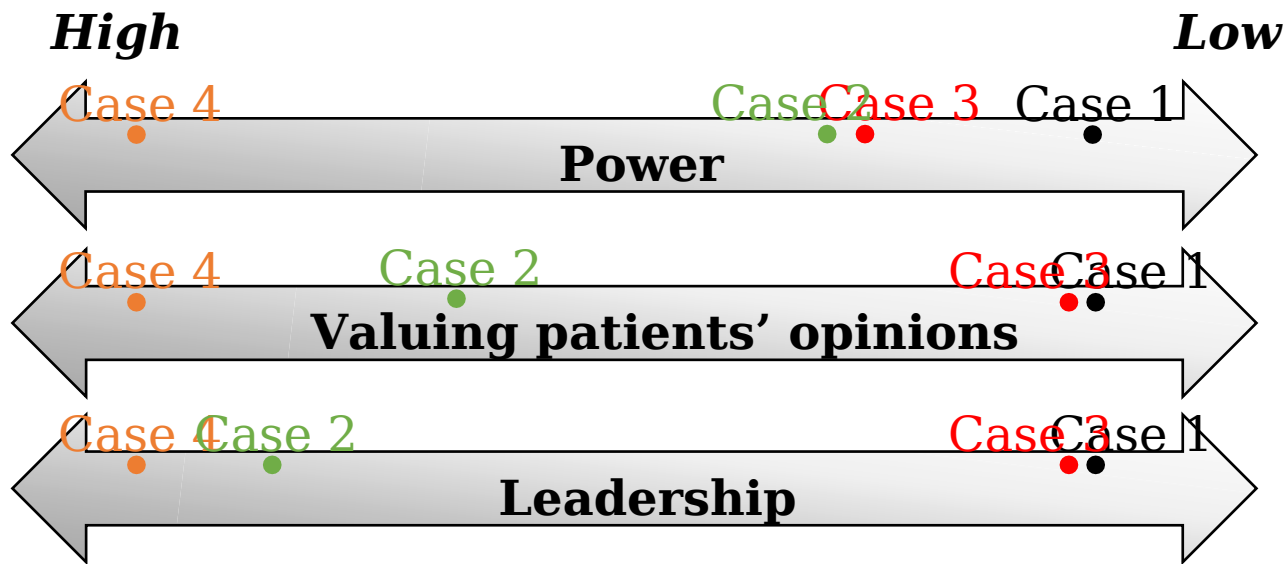


Figure 1 Contextual factors for each mental health organization

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Questions for the interviews to professionals (psychologists, psychiatrists, nurses, educators and other professionals)

Introduction:

- Which is your role within the organization? How long have you been in this role?
- Which activities are you daily performing in the organization?
- Can you please give me an example of an activity performed by your organization that have been designed and/or implemented with users or caregivers?

Option A: If he/she does not remember any activity designed and/or implemented with users or caregiver

- Is there any type of networks of stakeholders (i.e. volunteers, caregivers, patients, professionals) that patients can use for creating trusting and mutual relationships? Can you provide me an example?
- Does this network improve the well-being and health of patients and/or the social and health services? Can you provide me an example?
- Do you and your organization promote events or provide educational material to this network for enriching its capabilities useful for being involved in the creation or improvement of the social services? Can you provide me an example?
- Do you involve patients for deciding treatments and recovery path? Does the relationship between professionals and patient change among the recovery path?
- Which information should be shared with patients for giving them the capabilities and knowledge to be involve in the decision of their recovery path?
- Do you use any technologies or tools for the sharing of information with patients?
- Why do patients refer to this mental health organization? Can they choose the psychiatrist that they prefer?
- Do you think that informing patient can be risky?

Interviewer reports an example where patients were involved in a decision-making process.

- What do you think of this example? Do you share the values and objectives of this approach? Why?
- Which may be the benefits or the risks of this approach for patients?
- Would be possible to adopt the same approach in your organization? Why?

Option B: If he/she remembers any activity designed and/or implemented with users or caregiver

Referring to the initiative of patient involvement that the interviewee reports:

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3 • Who had the idea of involving patients? Which actors are involved?
4
5 • Why did you decided to implement this activity?
6
7 • How do you have implement this activity?
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9 • Do you have defined together with patients and/or other stakeholders objectives, activities as well as roles,
10 deadlines, objectives and methods for implementing initiatives? Can you provide me an example?
11
12 • Do you have estimated the economic and social return of involving patients and/or other stakeholders? If
13 yes, how do you do?
14
15 • Do you define standardized approaches for involving patients and/or other stakeholders continuously over
16 time?
17
18 • Which organizational barriers have you faced in involving patients?
19
20 • How professional have reacted to the decision of involving patients in daily activities?
21
22 • Does the relationship between patients and professionals has changed during the implementation of the
23 activity? If yes, how has it changed?
24
25 • Do patients understand the importance of being involved in taking decisions about their recovery path?
26 How many patients are willingness to participate? Do you think that the involvement of patents can be risky?
27
28 • Do you share values and objectives of involving patients?
29
30 • Which can be the benefits and risks of involving patients?
31
32 • Which limits have this approach?

33
34 *Final question for both options A and B:*

- 35 • Does your organization have a network of different actors (volunteers, patients, caregivers, professionals)
36 that supports patients? Can you provide me an example?
37
38 • Does this network improve the health and well-being of patients and the effectiveness of healthcare
39 services? Can you provide me an example?
40
41 • Do you (or your organization) organize training courses, workshops or other events for the network's actors,
42 to provide them all needed competences and capabilities for being involved in organization's activities?
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