## Implementing co-production in mental health organizations

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Implementing co-production in mental health organizations

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
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Introduction

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

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

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

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

In the past decade, co-production approaches have been increasingly adopted in the healthcare sector, especially in regard to chronic or long-term care (Realpe and Wallace, 2010). The benefits of involving stakeholders in the planning and delivery of care have been proved by various positive outcomes at both individual and organizational level (Mulliez, et al., 2018). The involvement of patients impacts positively on their health and wellbeing (Agha, et al., 2018; Gillard, et al., 2016; Bee, et al., 2015), patients’ satisfaction (Burns, et al., 2014) and patient/professionals’ relationships (Bovaird, 2007), the quality of services (Henderson, et al., 2004), and it reduces readmission rates, stigma and prejudices (Thornicroft and Tansella, 2005).

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

Among the several contextual factors reported in the literature, power, professionals’ opinion and leadership have been widely debated.

The first contextual factor concerns a challenging implication of co-production that entails the redistribution of power among clinicians, patients and other informal actors (Lambert & Carr , 2018). Professionals must 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.
Method

To increase the external validity of results and robust conclusions, we opted for a multiple case study research design. (Yin, 2003). 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 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.

Data collection

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

Thirty interviews were conducted in four Italian mental health organizations 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).

Case 4 had adopted co-production for more than three years, while other cases had just started to do so. The sample comprised 12 interviews with professionals (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 made it possible to check for any incongruences among groups and any peculiarity of each specific group.

Data analysis

The analysis of the cases had three aims: mapping co-production initiatives, studying the contextual factors and the level of co-production of each mental health organization. These three lenses of analysis enabled description and comparison of co-production implementation by the four mental health organizations.

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 is a well-known
framework of public involvement composed of five levels: ‘inform’, ‘consult’, ‘involve’, ‘collaborate’ and ‘empower’ (https://www.iap2.org.au) (International Association for Public Participation, 2014). The choice of the level was made according to the original definitions given by the IAP2 itself and examples provided by Burns et al. in 2014 (Burns, et al., 2014). The transcript screening, initiatives identification and clustering phases were executed twice to prevent any missing data or errors. The author, who had not been involved in the data analysis, checked the final classification, ensuring the completeness and correctness of results. In the first level, patients are informed about their illness to make them aware of the diagnosis and treatments. During the second level, patients are consulted to collect their feedbacks and preferences, while in the third phase patients are involved through decisional processes. In the fourth phase patients and clinicians collaborate as partners, having the same influence in identifying problems and proposing alternatives. The fifth and final level assigns the power to patients, enabling them to make decisions by themselves.

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

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

This section describes the adoption of co-production by mental health organizations. It focuses on the initiatives implemented and the level of co-production implemented. Moreover, it 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 reported in the appendix.

Cases propose diverse activities with which to inform patients, 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”

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

Although the literature states that patients, once they have achieved recovery, are able to manage and live
with their symptoms by gaining control over their illness (McGregor, et al., 2014), only centre 4 enabled patients
to be empowered and to take decision on their own. Patients in case 4, who were identified as “expert patients”,
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.”

They belong to a group composed of educators and psychiatrists that collaborate to support complex patients.
They not only participate in the group but also coordinate it, ensuring effective communication and
management between professionals and patients. Similarly, expert patients can coordinate a group of other
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.”

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

**Contextual factors**

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

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

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

Instead, cases 1, 2 and 3 preferred to maintain existing professionals’ roles and power dynamics of the organizations. Informal actors were not part of the organizations and did not have any role. Professionals were free to choose the type of interaction with informal users according to their willingness to create partnerships.

Although professionals are not forced to collaborate with informal actors, some of them seemed interested in participating in non-clinical organizations’ activities. There are some differences within this scenario. While professionals in cases 2 and 3 shared roles and responsibilities with informal actors in non-clinical organizations, professionals in case 1 were more reluctant to collaborate at the same level with non-clinical actors.

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

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

**Patient in case 4:** “I am involved in all activities. Professionals have trusted in my capabilities, giving new opportunities that have increased my self-esteem.”

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

**Educator in case 3:** “In general, professionals do not think that users’ knowledge might be a resource for themselves and for other patients.”

While the majority of professionals in case 2 supported patients’ preferences and knowledge, many professionals in cases 1 and 3 were still sceptical.

**Professional in case 1:** “Co-production activities seem to be linked to some specific professionals. The majority of professionals are not interested. I feel alone.”

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

**Professional in case 4:** Co-production is a working approach that we, as an organization, are trying to adopt as much as possible. It is effective, efficient, as well as demanding.
They had also modified the traditional model of communication, enhancing the collaboration of stakeholders in all activities. Leaders in case 2 had just started to adopt a similar approach as they were trying to modify the traditional view of the organization by implementing courses for professionals.

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

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

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

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

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

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**Level of adoption**

Each of the four organizations provides different services, as shown in Table 2. Daily Centre and Psychological Social Centre provide care to outpatients, while High Intensive Care and Hospital Centre treat acute cases. Organizations of patients, caregivers and other non-profit entities perform activities that complement the traditional clinical care.

As displayed by Table 2, organizations adopt both high and low levels of co-production. The low co-production level leaves existing stakeholders free to decide the number and types of partnership with external stakeholders. They do not involve external actors in the organizational structure of the service. Thus, they are solely responsible for taking final decisions. Instead, the high co-production level obliges existing stakeholders to involve systematically other actors in decision-making processes. External actors become part of boards and teams that take decisions about the service. According to the level of co-production, decision-making power can be more or less centralised.

1 Complete descriptions of each structure are provided in the appendix
Case 4 is the only one that had a high level of coproduction in all its services. Patients, caregivers and community were directly involved in the governance of all services of the organization, collaborating in partnerships with professionals. The level of power between professionals and other stakeholders was the same, and all decisions were taken jointly. Concurrently, case 4 did not have any non-clinical organizations, because external stakeholders (e.g. patients and caregivers) were involved within the existing clinical one. Instead, almost all other cases had at least one non-clinical organization, and the high level of co-production was only adopted in some non-clinical organizations.

Discussion

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

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

According to Table 4, case 4 is the organization with the highest level of involvement and co-production. This well-established adoption of co-production is related to high support by leaders and professionals and the distribution of power. To achieve this scenario, leaders in case 4 stated a new vision and communication model that enabled the large majority of professionals to adopt co-production in many organizational activities.
Instead, cases 1 and 3, which had the lowest level of involvement and co-production, did not have the support of leaders and professionals and distributed power. Leaders in cases 1 and 3 had neither changed their organizations’ culture and structure nor involved users constantly in time. They preferred to adopt co-production for few activities limited in time, leaving professionals free to decide whenever to adopt it. Thus, co-production was an ‘add-on’ to the existing activities. Finally, case 2 seems to be a third approach in between the previous two groups. Although it adopted a low-level of co-production within its organization, the number of activities undertaken were numerous and long-lasting. This scenario is confirmed by the contextual factors.

While the support of leaders and professionals for co-production is medium-high, power is not distributed within the organization. Professionals and leaders in case 2 seemed to value co-production principles but were not willing to modify the internal organizational structure or their roles and responsibilities. Thus, case 2 had succeeded in modifying the existing culture, influencing professionals’ perceptions against co-production but it had not changed the structure and roles of the organization.

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

**Conclusion and future research**

Co-production may be one possible solution to the current challenges of mental health systems, because of its capacity to ensure interdisciplinary approaches, points of view and knowledge (Nyström, et al., 2018). This
paper has sought to describe the implementation of co-production in four mental health organizations, giving
practical examples of co-production activities and studying the influence of the 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 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-production rarely
studied (Stott and Johnson, 2018), but also the evidence of co-production’s positive effect on the quality of
treatment and care is not clear (Jo and Nabatchi, 2018; Lea, et al., 2016). Proof of an additional value of co-
production in comparison to the traditional delivery of care is a key driver for convincing clinicians, mental
health organizations (Boardman and Shepherd, 2011) and policy-makers (Pagatpatan and Ward, 2017) to
adopt it. More validated tools will be needed to evaluate patient participation (Manafò, et al., 2018), especially
in the mental health sector.

This study has limitations. Although it is a multiple case study that makes it possible to collect and compare
different approaches and results, the context of all cases is very specific. All the centres analysed were located
in Italy and had similar structure, culture and policies. Thus, the present study is only a first step of research
in this field.
Dictionary

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

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

Daily Centre is a place where people can learn various capabilities, such as: interacting with other actors, taking care of themselves and managing their routine.

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

Patients’ organizations are supporting groups of patients who have completely recovered and decide to support other patients.

Caregivers’ organizations are voluntary organizations of caregivers that support other caregivers throughout patients’ recovery.

Voluntary organizations are responsible for all entertainment activities such as weekend trips, cinema, dinners and sport’s meetings.

Appendix

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

***please, place TABLE 3 here***
References


McGregor, J., Repper, J. and Brown, H. (2014), "'The college is so different from anything I have done'. A study of the characteristics of Nottingham Recovery College", The Journal of Mental Health Training, Education and Practice, Vol. 9 No. 1, pp. 3-15.


Enablers for Implementing co-production in mental health organizations

Abstract

Purpose: The aim of this paper is to facilitate effective implementation 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 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 information and other related sources. The results and official documents of organizations have been compared through 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 to contribute in guiding describing how mental health organizations in the implementation of co-production. It gives insight on how to modify the internal structure of mental health centers for ensuring the systematic adoption of co-production. Moreover, it lists possible practical activities for engaging patients according to their health status.

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

Type: Research Paper
Manuscript

Introduction

Mental health is one of the priorities of many national healthcare systems of developed countries (Satinsky, et al., 2018). Since 2007, mental disorders have been the second largest worldwide cause of health loss, with an increasing rate of 12% (World Health Organization, 2018). In 2017, the most popular disorders were depression and anxiety, with respectively 4.52% and 3.76% of the total Years Lived with Disability of worldwide population (Healthdata, 2018). To corroborate these results, a recent study by the World Health Organization (WHO) estimates that depression and anxiety disorders reduce the global productivity by 1 trillion US$ each year (World Health Organization, 2017) and the number of people affected by these diseases had raised in the last ten years (Healthdata, 2018).

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

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

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

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

In the last decade, co-production approaches have been increasingly adopted in the healthcare sector, especially in regard to chronic or long-term care (Realpe and Wallace, 2010). The benefits of involving stakeholders in the planning and delivery of care have been proved through various positive outcomes at both individual and organizational level (Mulliez, et al., 2018). The engagement of patients impacts positively on their health and wellbeing (Agha, et al., 2018; Gillard, et al., 2016; Bee, et al., 2015), patients’ satisfaction (Burns, et al., 2014) and patient/professionals’ relationships (Bovaird, 2007). Through co-production, the quality of services (Henderson, et al., 2004), and caregivers become able to take informed decisions. Thus, healthcare organizations should opt for a set of initiatives that enhance the adoption of co-production by patients it reduces readmission rates, stigma and caregivers’ prejudices (Thornicroft and Tansella, 2005).

Patients might not be able to be involved in Despite the benefits of co-production activities for their current health status (Burns, et al., 2014). Centres have to enable co-production introducing distinct approaches that incentivize the involvement of all patients over time. At the beginning of the treatment, patients are usually in an emotional, behavioural and cognitive condition of numbness caused by the diagnosis (or by the physical...
and mental consequences of a critical health episode). They perceive themselves as behaviourally unequipped to face their new health status. Thus, they are unable to take an active position in their recovery, but they can be engaged in simple activities or preliminary actions toward recovery. Then, patients become more conscious of their condition and aware of their health status, but they are unconfident in being autonomous and ask constantly feedbacks from professionals and clinicians. Finally, patients accept their new health status and would like to achieve a “new normality” (Barello and Graffigna, 2015), being able to be proactive in decision-making. This last phase consents the application of co-production at its maximum level, where patients, caregivers, professionals and other informal actors collaborate in partnership sharing decisional power, enhancing democracy and effectiveness of organizational outcomes (Norris, et al., 2017).

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

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

The first contextual factor concerns a challenging implication of co-production that entails the redistribution of power among clinicians, patients and other informal actors (Lambert & Carr, 2018). Professionals must 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.
Method

To increase the external validity of results and robust conclusions, we opted for a multiple case study research design (Yin, 2003). 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 an a conference connected to a research 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 an 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).
Case 4 had adopted co-production for more than three years, while other cases had just started to do so. The sample comprised 12 interviews with professionals (psychiatrists, psychologists, 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 to check for any incongruences between groups and any peculiarity of each specific group.

Thus, results have been gathered together according to 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 of view on mental health organizations. 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, one of the most famous models is a well-known framework of public involvement proposed by the literature. IAP2 proposes composed of five levels of engagement: “inform”,...
‘consult’, ‘involve’, ‘collaborate’ and ‘empower’ (Burns, et al., 2014; International Association for Public Participation, 2014). The first phase informs patients about their disease, in order to let them understand the diagnosis, treatments and future obstacles choice of recovery, moving back to their routine activities. The second phase starts to involve patients asking them the level was made according to the original definitions given by the IAP2 itself and examples provided by Burns et al. in 2014 (Burns, et al., 2014). The transcript screening, initiatives identification and clustering phases were executed twice to prevent any missing data or errors. The author, who had not been involved in the data analysis, checked the final classification, ensuring the completeness and correctness of results. In the first level, patients are informed about their illness to make them aware of the diagnosis and treatments. During the second level, patients are consulted to collect their feedbacks and preferences, while in the third phase involves patients throughout are involved through decisional processes, in order to guarantee the constant collection of patients’ opinions. In the fourth phase patients and clinicians collaborate as partners the same level, having the same influence in identifying problems and proposing alternatives. Finally, the last The fifth phase and final level assigns the power to patients, enabling them to make decisions by themselves (IAP2, 2014).

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

Finally, the last lens of analysis investigates the influence of co-production’s adoption on the organizational structure. Stakeholders not ‘in’ the organization, such, this qualitative evaluation framework emerged as particularly effective to classify the results and measure the organizations’ attitude and capacity of involving patients, and caregivers, can be involved differently according to the level of co-production. Health organizations may involve stakeholders within their structure or be partners with external organizations of patients and caregivers. The former approach has been called “high-level co-production” because it requires the restructuring of the current top-down structure (Mulliez, et al., 2018). Stakeholders are involved in the existing organization, making their involvement easier and more systematic. Instead, the latter approach, termed “low-level co-production”, allows mental health organizations to decide on which decisions should involve stakeholders. Patients or caregivers’ organizations are outside the mental health ones, so that mental 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 on the relative impact on organizations’ structures, initiatives implemented and the level of co-production implemented. Moreover, it 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 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.”
During the collaboration phase, professionals collaborate in partnership with informal actors at the same level of power. Actors involved in this phase are asked to take decisions regarding various issues: for instance, everyday activities of centres, leisure and extra activities and patient treatments. Decisions regarding the organization and its activities are usually taken by a mixed group composed of patients, caregivers, volunteers and professionals. Instead, choices related to patients’ treatments are established by professionals and patients during clinical visits. Some collaborations are limited in time because they are related to a specific projects or events, such as creative workshops, conferences and specific courses (case 1 and 3). Other collaborations are accomplished periodically as meetings to decide organizations’ activities and patients’ 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.”

Although the literature states that patients, once they have achieved recovery, are able to manage and live with their symptoms by gaining control over their illness (McGregor, et al., 2014), only centre 4 enabled patients to be empowered and to take decision on their own. Patients in case 4, who were identified as “expert patients”, 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.”

They belong to a group composed of educators and psychiatrists that collaborate to support complex patients. They not only participate in the group but also coordinate it, ensuring effective communication and management between professionals and patients. Similarly, expert patients can coordinate a group of other 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.”

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

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

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

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

Instead, cases 1, 2 and 3 preferred to maintain existing professionals’ roles and power dynamics of the organizations. Informal actors were not part of the organizations and did not have any role. Professionals were free to choose the type of interaction with informal users according to their willingness to create partnerships.

Although professionals are not forced to collaborate with informal actors, some of them seemed interested in participating in non-clinical organizations’ activities. There are some differences within this scenario. While professionals in cases 2 and 3 shared roles and responsibilities with informal actors in non-clinical organizations, professionals in case 1 were more reluctant to collaborate at the same level with non-clinical actors.

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

The second contextual factor concerns professionals’ opinions about patients’ knowledge and skills.

Professionals in case 4 seemed to value users’ opinions and recognize their knowledge as ‘experts by experience’ not only for decisions relating to the centre but also for treatment options.

**Patient in case 4:** “I am involved in all activities. Professionals have trusted in my capabilities, giving new opportunities that have increased my self-esteem.”

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

**Educator in case 3:** “In general, professionals do not think that users’ knowledge might be a resource for themselves and for other patients.”

While the majority of professionals in case 2 supported patients’ preferences and knowledge, many professionals in cases 1 and 3 were still sceptical.

**Professional in case 1:** “Co-production activities seem to be linked to some specific professionals. The majority of professionals are not interested. I feel alone.”
The third contextual factor relates to the leadership of mental health organizations. Case 4’s leaders had a clear vision of co-production, spreading it through several training courses for professionals.

**Professional in case 4:** Co-production is a working approach that we, as an organization, are trying to adopt as much as possible. It is effective, efficient, as well as demanding. They had also modified the traditional model of communication, enhancing the collaboration of stakeholders in all activities. Leaders in case 2 had just started to adopt a similar approach as they were trying to modify the traditional view of the organization by implementing courses for professionals.

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

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

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

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

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

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**Level of co-production’s adoption**

Each of the four organizations provides different services, as displayed in Table 2. Daily Centre and Psychological Social Centre provide care to outpatients, while High Intensive Care and Hospital Centre follow/treat acute cases. Organizations of patients, caregivers and other non-profit entities perform activities that complement the traditional clinical care.

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

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

Organizations adopt co-production at different both high and low levels using both approaches, according to
their willingness to change the existing top-down structure of co-production. The low co-production level leaves
existing stakeholders free to decide the number of types and types of partnership with external stakeholders.
They do not involve external actors in the organizational structure of the service. Thus, they are the only one
in charge to take solely responsible for taking final decisions. Instead, the high co-production level
obliges existing stakeholders to involve systematically other actors in taking decisions, decision-
making processes. External actors become part of boards and teams that take decisions about the service.

According to the type, the decisional level of co-production, decision-making power can be more or less
centralised.

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Case 4 is the only one that had a high level of coproduction in all its services. Patients, caregivers and
community were directly involved in the governance of all services of the organization, collaborating in
partnerships with professionals. The level of power between professionals and other stakeholders
was the same, and all decisions were taken jointly. Concurrently, case 4 did not have
any non-clinical organizations, because external stakeholders (e.g. patients and caregivers) were involved
within the existing clinical one. Instead, almost all other cases had at least one non-clinical organization,
and the high level of co-production was only adopted in some non-clinical organizations. Indeed, patients
and other informal actors usually support the involvement of professionals in non-clinical organizations’
activities, implementing a high level of co-production. While professionals do not involve external stakeholders;
they accept to collaborate with other actors but only outside their clinical organizations.
Activities

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

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

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

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

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

Patients and caregivers are involved in some decision-making process, having the opportunity to influence decisions. (1) Patients, willing to work for the centre, take an appointment with professionals to discuss activities and the objectives of this role. Then, clinicians assign patients to a specific activity, as front-office collaborator, coordinator of Daily Centre and supervisor of Psychological Social Care. The activity's assignation is made according to patients' capacity of gaining responsibility and preferences, which are highlighted during the meeting. (2) Similarly, professionals of the psychological social centre of case 3 organize
each morning a meeting with patients and assign to them a daily tasks (e.g. cleaning toilette, gardening, cooking) based on their preferences. Finally, (3) Case 4 involves patients and other informal actors in the development of new projects, in order to enrich the research with different point of views and increase the effectiveness of the outcome.

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

Once patients have completed their recovery, they are able to “overcome or manage dieabling symptoms by gaining mastery over the illness” (McGregor, et al., 2014). Only centre 4 enables patients to be empowered and to take an active part in their life through several initiative. (1) Once patients have completed their recovery and have participate to a set of courses, they are identified as “expert patients” and have the possibility to take part to a group composed of educators and psychiatrics that coordinate and share opinions about specific complex patients. The introduction of the expert patient in the team enriches traditional clinical knowledge with the experiential knowledge that no one of professionals have. Giving the importance of the expert patient in
the team (Roberts, et al., 2011), he/she is the coordinator of the group, ensuring an effective communication and management of patients’ recovery. (2) Expert patients, working in the Daily Centre, are asked to organize activities for a group of patients every morning. They enable the recovery process because their role increases hope in other patients and the creation of empathic relationships. This role benefits also expert patients increasing their self-esteem.

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

Discussion

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

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

***please, place TABLE

The analysed mental health organizations have confirmed several enablers for the systematic involvement of stakeholders. Case 1 and 3 have recognized the importance of organizing training courses for patients and case 4 also for caregiver and professionals, in order to give them all needed competences and knowledge for taking part to co-production activities (Vaggemose, et al., 2018; Freeman4 here***

According to Table 4, case 4 is the organization with the highest level of involvement and co-production. This well-established adoption of co-production is related to high support by leaders and professionals and the distribution of power. To achieve this scenario, leaders in case 4 stated a new vision and communication model that enabled the large majority of professionals to adopt co-production in many organizational activities.
Instead, cases 1 and 3, which had the lowest level of involvement and co-production, did not have the support of leaders and professionals and distributed power. Leaders in cases 1 and 3 had neither changed their organizations’ culture and structure nor involved users constantly in time. They preferred to adopt co-production for few activities limited in time, leaving professionals free to decide whenever to adopt it. Thus, co-production was an ‘add-on’ to the existing activities. Finally, case 2 seems to be a third approach in between the previous two groups. Although it adopted a low-level of co-production within its organization, the number of activities undertaken were numerous and long-lasting. This scenario is confirmed by the contextual factors.

While the support of leaders and professionals for co-production is medium-high, power is not distributed within the organization. Professionals and leaders in case 2 seemed to value co-production principles but were not willing to modify the internal organizational structure or their roles and responsibilities. Thus, case 2 had succeeded in modifying the existing culture, influencing professionals’ perceptions against co-production but it had not changed the structure and roles of the organization.

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

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

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

Results reveal the necessity to re-organizing activities and resources of current mental health organizations (Boardman and Shepherd, 2011) that decide to adopt co-production, modifying the traditional service system 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 systems, because of its capacity to ensure interdisciplinary approaches, points of view and knowledge (Nyström, et al., 2018). This paper has sought to 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.

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

This study contains limitations. Firstly, the number of casesAlthough it is limited due to the shortage of Italian mental health organizations a multiple case study that are adopting co-production. Secondly, it is possible to collect and compare different approaches and results, the context of all cases is very specific. All the centres analysed are located in Italy with similar structure, culture and policies. Thus, the present study is just a first insight of future research in this field.
**Dictionary**

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

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

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

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

*Patients’ organizations* are a supporting group of patients, who have completely recovered, and decide to support other patients.

*Caregivers’ organizations* are voluntary organizations of caregivers that support other caregivers throughout patients’ recovery.

*Voluntary organizations* collaborate with the mental centre are responsible for all entertainment activities such as weekend trips, going to the cinema, having dinner together, and doing sports, sport’s meetings.

**Appendix**

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

***please, place TABLE 3 here***
References


## Implementing co-production in mental health organizations

### Table 1

<table>
<thead>
<tr>
<th>Case 1</th>
<th>Case 2</th>
<th>Case 3</th>
<th>Case 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health organization location</td>
<td>Como- Lombardy</td>
<td>Saronno- Lombardy</td>
<td>Treviglio- Lombardy</td>
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<tr>
<td>Number of interviews</td>
<td>-1 Nurse</td>
<td>-1 Psychiatrist</td>
<td>-1 Psychologist</td>
</tr>
<tr>
<td></td>
<td>-2 Educators</td>
<td>-2 Educators</td>
<td>-2 Educators</td>
</tr>
<tr>
<td></td>
<td>-4 Patients</td>
<td>-1 Patient</td>
<td>-4 Patients</td>
</tr>
<tr>
<td></td>
<td>-2 Relatives</td>
<td>-2 Relative</td>
<td>-1 Volunteer</td>
</tr>
</tbody>
</table>

Table 1 Case studies’ interviews
Implementing co-production in mental health organizations

Table 2

<table>
<thead>
<tr>
<th>Services provided in each organization and level of co-production in decision making</th>
<th>Case 1</th>
<th>Case 2</th>
<th>Case 3</th>
<th>Case 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily Centre</td>
<td>low</td>
<td>low</td>
<td>low</td>
<td>high</td>
</tr>
<tr>
<td>Psychological Social Centre</td>
<td>low</td>
<td>low</td>
<td>low</td>
<td>high</td>
</tr>
<tr>
<td>High Intensive Care</td>
<td>low</td>
<td>low</td>
<td>low</td>
<td>high</td>
</tr>
<tr>
<td>Hospital centre</td>
<td>low</td>
<td>low</td>
<td>low</td>
<td>high</td>
</tr>
<tr>
<td>Patients’ organization</td>
<td>low</td>
<td>high</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregivers’ organization</td>
<td>high</td>
<td>high</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Voluntary organization</td>
<td>high</td>
<td>high</td>
<td>high</td>
<td>high</td>
</tr>
</tbody>
</table>

Table 1 Services provided in each organization and level of co-production in decision-making
# Implementing co-production in mental health organizations

## Table 3

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

*Table 1 Activities put in place by each case organized according IAP2 framework*
Implementing co-production in mental health organizations

Table 4

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

Table 4 Comparative factors of mental health organizations
Implementing co-production in mental health organizations

FIGURE 1
FIGURE 1

High

Power

Valuing patients’ opinions

Leadership

Low

Case 4

Case 2

Case 2

Case 3

Case 3

Case 1

Case 1

Figure 1 Contextual factors for each mental health organization
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 your 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:
• Who had the idea of involving patients? Which actors are involved?
• Why did you decide to implement this activity?
• How do you have implement this activity?
• Do you have defined together with patients and/or other stakeholders objectives, activities as well as roles, deadlines, objectives and methods for implementing initiatives? Can you provide me an example?
• Do you have estimated the economic and social return of involving patients and/or other stakeholders? If yes, how do you do?
• Do you define standardized approaches for involving patients and/or other stakeholders continuously over time?
• Which organizational barriers have you faced in involving patients?
• How professional have reacted to the decision of involving patients in daily activities?
• Does the relationship between patients and professionals has changed during the implementation of the activity? If yes, how has it changed?
• Do patients understand the importance of being involved in taking decisions about their recovery path? How many patients are willingness to participate? Do you think that the involvement of patients can be risky?
• Do you share values and objectives of involving patients?
• Which can be the benefits and risks of involving patients?
• Which limits have this approach?

Final question for both options A and B:
• Does your organization have a network of different actors (volunteers, patients, caregivers, professionals) that supports patients? Can you provide me an example?
• Does this network improve the health and well-being of patients and the effectiveness of healthcare services? Can you provide me an example?
• Do you (or your organization) organize training courses, workshops or other events for the network’s actors, to provide them all needed competences and capabilities for being involved in organization’s activities?