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# Creating Equality for those in Crisis

## Transforming Acute Inpatient Mental Health Services through Co-Production

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### Abstract

The 21st century has seen an increasing focus on the concept of co-production in seeking to tackle the tokenistic approach often taken by services to recovery in mental health. It originated from the scholarly work of Elinor Ostrom in America in the 1970's and was further developed through the works of Edgar Cahn. In a bid to create a service that is more recovery orientated, many community mental health services have adopted co-production as a foundation for all work they conduct with service users/family members and carers. It is reported that co-production can be transformative in practice if done correctly. More specifically, this can include circumstances where individuals are presenting in crisis. However, there is a paucity of research/perspectives in this specific area. The aim of this perspective paper is to highlight such literature whilst

also debating the ethical considerations to co-production within the acute inpatient mental health services.

***Keywords:*** Co-Production, Ethics, Recovery, Acute Inpatient, Service Improvement

## Introduction

Co-production is a concept that is difficult to define due to its complex history within a variety of services (Brandsen and Honingh 2015; Filipe et al. 2017). The principle was conceptualised through the work of Elinor Ostrom in the 1970s and has grown exponentially since. Co-production was further developed by Anne Coote (2000) and Edgar Cahn (2000) who proposed its use within public and health services. Co-production as a principle, is intrinsically linked to that of recovery. Recovery, according to Anthony (1993) is a process whereby one lives a satisfying, hopeful and contributing life even with the presence of mental health challenges. This new understanding of what recovery means led to a recovery movement which sought mental health reform so that services would become less coercive, and more recovery orientated.

Co-production, in recent years, has been identified as one such principle/approach that could support services in this endeavour (Norton 2019). Given the rise of the recovery movement, co-production has become central to developing mental health services. Ireland, like many other jurisdictions have begun to embrace a recovery philosophy. This has become evident through national frameworks and policies including '*Sharing the Vision*' (Department of Health 2020) and '*A National Framework for Recovery in Mental Health*' (Health Service Executive 2017). However, inpatient services still operate under the premise of the biomedical model for several reasons. This includes professionals' unwillingness to change. It also due to a risk adverse and blame culture brought about through legislation for those working in the system (Vaeggemose et al. 2018; Norton 2021). As co-production has evolved, its use within acute services has been posited by authors such as Alakeson and colleagues and Norton (2019). However, little to no method or guidance has accumulated so far into how such practices can occur within such settings. As such, the aim of this paper is to highlight and debate the ethical considerations of co-production

within acute inpatient mental health services. Finally, this paper will also provide accounts from experiential and learned knowledge perspectives into this issue.

## Co-Production in the Acute Inpatient Setting – What does the Evidence Tell us?

There is a paucity of evidence into co-production within inpatient settings. Reasons for this include the dominance of the biomedical approache along with ethical considerations which need addressing in such settings (Tuurnas et al. 2015; Vaeggemose et al. 2018; Norton 2019). This is imperative due to the risk of co-production becoming an unfulfilled ethos for mental health services. It is also important because if we are to embrace the recovery philosophy moving forward, co-production needs to be in every aspect of the service (Norton 2019; Swords & Houston 2021). The biomedical model has been dominant within mental health services for many years. This model supports a power imbalance between treating physicians and the service users who utilises services. Co-production is strongly associated with empowerment, which historically has often conflicted with the biomedical model (Hayes and Hannold 2007; Kirkegaard & Andersen 2018). As a result, having co-production within acute mental health services creates an ideological conflict with service norms (Pinfold et al. 2015). This may cause resistance from traditional staff to uphold its values despite a willingness to do so (Bhaskar and Danermark 2006).

Another reason for the lack of co-productive practice within acute mental health services relate to the many ethical considerations associated with co-production in such settings. Generally, service users are admitted to acute inpatient settings for several reasons. One of which includes the lack of capacity to give informed consent to treatment regimens (Sugiura et al. 2020). The question here relates to the ability of a person to comprehensively provide informed consent to join the co-productive relationship (Norton 2019). As stipulated through the perspectives below. Co-production is quite easy to implement in such settings as it is a way of working rather than an additional task needed to be done. As Alakeson et al. (2013) states, if co-production is fully embraced by a service, then the principle can be used in every therapeutic interaction, including crisis.

## The Multiple Realities of Co-Produced Healthcare in Inpatient Settings

In the following section, both authors present perspectives on co-production within acute services, using an auto-ethnographical approach (Méndez 2013). This methodology allows for researchers to make sense of a phenomenon based on their own experiences. It is important to highlight that both authors have been researching the challenges of recovery and co-production in recent times. These reflections are based on such projects undertaken. Given the lack of guidance regarding co-production in acute settings, it is imperative that we explore the narratives of those on the frontline in order to derive recommendations for practice.

## The Lived Experience Perspective

When I first used services, it was for the positive symptoms of schizophrenia. This was a very daunting time for a young student nurse. Despite such depictions I imagined from my love of TV shows, the acute mental health services in my locality were different. However, despite this, there were traits of the old system still at play. Psychiatry still ruled over such settings and bared overall responsibility for the treatment of service users. Consequently, the biomedical model was evident in services. I remember queues of individuals lining up by the nurse's station waiting for medications, with little interaction from staff beyond this. Coercive treatment was still a feature, with the backing of governmental legislation such as *'The Mental Health Act 2001.'* However, despite this, snippets of recovery and co-productive practice seeped through to my care.

An example of co-production in action within inpatient settings came from a psychiatric nurse. One morning, a nurse was doing his morning rounds, dressing beds for individuals in the ward. A classic case of delivering rather than facilitating one might say. However, co-production came when he arrived to dress my bed. I remember getting into a conversation with him about my occupation of the time: nursing. We discussed how beds were dressed in the general wards compared to here. Suddenly, he asked me what way I would like my bed dressed. Seems like a simple gesture, but for me this always stuck out as the start of my recovery. Someone saw me for who I was, not a disease, but a person with unique qualities and

needs. However, this was also an example of good co-productive practice. My opinions were sought. It was not tokenistic, it was genuine. I remember dressing my bed with him that day. Every step of the process was co-produced as I co-decided what order the sheets were put on and how the sheet ends would be folded. This may seem overly simplistic, but I felt valued in the interaction. My lived experience knowledge and expertise as a student nurse was drawn on. The nurse focussed on my strengths rather than my deficits. There was a sense of mutuality as he asked about my nursing experience and compared it to his own. There was reciprocity as he learned as much from me as I did from him. It was through this one interaction that I came to understand the true essence of co-production. It's as much about connecting with the individual and taking their will and preference under consideration within the co-productive space than just needing to get the job done.

As you can see from this simplistic but effective co-productive interaction, many of the characteristics that make up the principle are present (Health Service Executive 2018; Norton 2019). When I discuss co-production, I am always told, this can work in the community but how can this work within an inpatient setting. People are incapacitated, they have no opinion. The answer is simple, all one needs to do to practice in a co-productive way is to take a genuine interest in the person. Look at them as a unique person with unique interpretations of the world around them. The person may become an inpatient for numerous reasons, and as highlighted above can be there involuntarily, however, one can still practice in co-production if one simply considers the service user's point of view. Remember co-production is not a one-sided relationship. It is reciprocal, meaning that there is give and take in the relationship. Both parties, whether capacitated or not, can still work together, listen to each other, and develop a care plan that is conducive to everyone's needs without necessarily becoming uncompliant with governing bodies. As my inpatient stay continued, the therapeutic effects of this interaction were noted, which resulted in me being given the task, along with this nurse, of dressing every bed within the inpatient unit. Something that at the time I found utterly fulfilling.

## A Service Provider Perspective

Co-production focuses on changing the historical nature of everyday social relationships within mental health provision. It seeks to change the experiences of stakeholder groups from a construction of mental illness which is driven by a paternalistic discourse, to one which cultivates choice and autonomy. It is important to note that this is comparable to the development of new ways of thinking, interacting, and experiencing recovery in the late twentieth century (Swords & Houston 2020).

It is seen in the literature (Sugiura et al. 2020) how countries, especially in the westernised world, are seeking to address the shortcomings of legislation in relation to the Convention on the Rights of Persons with Disabilities (Sugiura et al. 2020). This is something which can hinder or support the process of co-production, especially in acute inpatient settings. However, the culture within services extends far beyond these legislative frameworks.

This was evidenced by Stainszewska et al. (2019) in their systematic review of the experiences of inpatient mental health services. There were four interlinking themes identified as core tenets of inpatient service experiences. Firstly, high quality relationships were viewed as fundamental in these acute settings. Secondly, mitigating against the possibility of coercion. Thirdly, a physical environment which is safe and promotes opportunities for development, and finally, authenticity in terms of the experiences of patient-centred care.

Reflecting on research from one of the lead authors of this paper (Swords 2021), participants who were involuntary or voluntary admitted agreed that it was the appropriate decision to take at the time. However, once admitted and their symptoms stabilised, individuals believed that they should be supported to engage in co-produced opportunities regarding the incipience of their recovery process.

Reflecting on the systematic review findings from Stainszewska et al. (2019), the term authenticity is particularly important for the process of co-production. It asks to what extent are people their true self when engaging and interacting with one another in this social world. Often, this takes place within the intersubjective space of everyday social interactions between stakeholder groups (Swords & Houston 2021). This space involves two or more people coming together and co-constructing a particular account of events (Walsh

& Lenart 1967). Intersubjectivity stems from the work of Alfred Schutz, who introduced the phenomenological study of society (Harrington 2000). It is in this space that the most intrinsic roots of culture are cultivated. Consequently, inpatient services must focus on the intersubjective spaces when creating opportunities for co-production.

The philosophy of personal recovery is unique and subjective (Lovell et al. 2020). For all stakeholders, language is the medium for how these experiences of co-production are constructed (Burr 1995; O'Reilly & Lester 2017; Swords & Houston 2021). These experiences are reflected in the thinking and understanding people have of services. People become 'conditioned' in their interactions due to the discursive practices which dominate the co-constructed meaning-making activities, including co-production. On paper, co-production is viewed as the process which can lead to better outcomes regarding recovery moving forward (Norton 2019; Swords 2019).

Given these reflections, the following section provides a framework for cultivating and understanding the everyday intersubjective spaces of in-patient mental health services. This can contribute to the process of creating equality in the relationships between users and providers of services moving forward.

## Social Constructionism: Plausible Ethical Framework for the Implementation of Co-Production

One plausible solution to creating a co-production space within such services is to adopt and implement a social constructionist framework [Table 1]. The theory of social constructionism describes peoples' interpretation of reality as being understood as the product of their interactions with others in society, as well as their own life experiences (Berger & Luckman 1966; Burr 1995; Swords & Houston 2021). Overtime, these social interactions lead to normative expectations on how those using and providing services should interact on an everyday basis. There is a growing body of evidence claiming that the dominant discursive practices within mental health services are being driven by a neo-liberal agenda (Jorgensen 2020; Moth 2020). The left column of the Table below represents the key pillars of Vivien Burr's (1995) interpretation of social constructionism. The right column illustrates how Burr's framework could

be used to make sense of in-patient service culture surrounding co-production.

Table 1: The Core Tenets of a Social Constructionist Framework

| Core Concepts | Deconstructing Service Culture |
|---|---|
| All Knowledge must be Questioned | No one account regarding mental illness/challenges + recovery + co-production tells the full truth. Multiple realities constructed by discursive practices. |
| Historical and Cultural Specificity of Social Reality | What are the normative social artefacts within a specific service culture regarding mental illness/challenges + recovery + co-production? |
| Symbolic Interactionism | What identities of patients, families, professionals, and policy are being constructed through social interactions within in-patient services? |
| Essentialism/Anti-Essentialism | To what extent is a person's mental health challenges/experiences + recovery beyond human influence? Are there limits to human agency? |
| Language | How is language structured and shaped regarding mental health challenges/illness + recovery + co-production within service culture? |
| Discourse | How has language been normatively structured in everyday service interactions – Focus on the "meanings, metaphors, representations, images, stories, statements" (Burr,1995, p.48) which reflect different experiences of mental illness/challenges recovery + co-production. |
| Power | To what extent do in-patients have access to the capabilities needed for human flourishment? |

Reflecting on the table, and focusing on in-patient services, a critical gaze must be taken to everyday discursive practices. Whether this is person-centred care plans, family meetings, interdisciplinary assessments, interagency meetings, and discharge planning. This also

extends to any policies and procedures underpinning these everyday service delivery activities. Ultimately, these are all products of human actions, which are the outcomes of social interactions. They can contribute to normative, co-constructed accounts of co-production (Hjelm 2014; O'Reilly & Lester 2017).

Therefore, by understanding the dominant discursive practices of these normative social interactions, there is a possibility for co-production to have successful outcomes. Table 1 provides possible questions that can help services to understand such discursive practices. Within the analysis of discourse, questions of who has the power arises. In other words, what body of knowledge is supporting the dominant narrative being co-constructed within each opportunity for co-production? Historically, interdisciplinary constructions of service delivery have been dominated by the biomedical paradigm (Norton & Swords 2020; Swords 2019). Therefore, in crises cultures, the risk narrative has, and continues to be a dominant discourse (Higgins & McGowan 2014; Perkins & Repper 2016; Swords and Houston 2020). Consequently, the concern for co-production is that the discursive practices of the biomedical model, combined with risk adverse actions, will limit the opportunities for choice, autonomy, and equality in decision-making (Sugiura et al. 2020).

Following consideration and application of the questions from Table 1, discussions concerning co-production opportunities within in-patient service delivery must start with questions of ontology (Swords & Houston 2021). Often, service delivery has already established an 'epistemological way' of understanding mental health, illness, and recovery. These include different perspectives from all stakeholders, including service users' and their families. They all bring their own perspectives of how mental health challenges and recovery should be understood and addressed.

From a service provider perspective, by beginning from a position of 'we know what is needed here', can lead to co-production becoming another driver of maintaining the 'status quo'. Instead of starting from this position, discussions should begin with an ontological understanding of how it has manifested for each person – 'their way of being in the world regarding their mental health challenges'. These questions must extend to interdisciplinary teams, families, and if plausible, community services. This involves people

reflecting on their own constructions of mental health, illness, and recovery, establishing an authentic narrative for each recovery journey. Reflective frameworks such as Houston's (2015) could be used alongside the social constructionist framework illustrated in Table 1. Houston's framework asks individuals to reflect on their own identity, and how this has been shaped by their experiences – childhood, education, family and work being 4 important identities one holds in their everyday life (Goodman 2012).

Extending beyond the deconstruction of the different competing epistemes embedded in service culture, co-production can begin with questions of what exactly is human flourishment? Translated from Aristotle's idea of 'eudaimonia', each individual's recovery process should focus on how they can reach their full potential (Ghaye 2010; Hinchliffe 2004). In conjunction with applying the theory of social constructionism (See Table 1), the capabilities model could cultivate and support an individual's agency, seeking to promote their capacity to reach their full potential (Nussbaum 2000; Sen 1993). Nussbaum identifies 10 factors which should be viewed as the necessary factors to reach human flourishment by using the capabilities model (Shinn 2014). This particular model could offer new possibilities for in-patient services moving forward and should be further explored.

This can contribute to recovery and co-production converging, rather than potentially diverging (Swords 2019). The capabilities model can provide a broad framework to adopt by key stakeholder groups once questions of ontology and human flourishment have been explored and identified. This can lead to recovery outcomes not being determined by pre-ordained assumptions. Instead, each unique subjective journey can be validated and supported through co-production. To support the claims made above, the following implications for practice were identified:

1 A recognition that co-production on paper and in reality, are two separate entities. Therefore, there needs to be a deconstruction of the everyday normative actions of key stakeholder groups who are constructing co-produced initiatives.
2 Third level education should adopt a co-productive approach to the training of staff so that future employees incorporate the perspectives of lived experience in all sectors.

3 When beginning co-produced initiatives and care plans, services must begin first with a focus on human flourishment. They must begin with questions regarding ontology. This can lead to a more authentic narrative of what personal recovery could be.
4 Given the complex history of co-production within a variety of services, the evidence base for co-production, specifically towards mental health services needs to be further developed to support its implementation.
5 If co-production is about constructing a journey with opportunity, choice and fulfilment, there is a requirement to integrate and consider the capabilities model.
6 Despite the lack of evidence, national and international policy needs to provide clear guidance on the implementation and sustainability of co-production in such settings moving forward.

## Limitations

This paper presents some theoretical possibilities when considering how services improve their approach to co-production within inpatient settings. These reflections are from recent research projects undertaken and completed by both authors. However, there is limitations to the paper. In order to further strengthen these theoretical ideas and contributions, further research would be needed to strengthen the evidence base for the claims made by the authors. Furthermore, it only takes into consideration the Irish context, and therefore, no generalisations can be made beyond Ireland.

## Concluding Comments

This paper focussed on co-production in acute mental health services. It has examined the evidence base for co-production in such settings. Building on the dearth of evidence published, the authors presented new possible avenues to explore regarding creating equality in acute mental health services. Furthermore, we co-constructed several necessary implications for co-production to converge with aspirations of personal recovery moving forward. This aligns with the vision proposed by Alakeson and colleagues that could lead to systemic change for mental health services. In other words, an acute service that is participatory in nature, and embeds co-production in every interaction.

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