Evaluation of co-production processes in a community-based mental health project in Wandsworth

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Executive Summary

The notion of partnerships and co-production has been introduced in the latest public services policies, suggesting that the key to reforming them is to encourage users to design and deliver services in equal partnerships with professionals. It is argued that co-production has the potential to deliver a major shift in the way we provide health, education, policing and other services in ways that make them much more effective, more efficient, and therefore more sustainable.

This report presents findings from an evaluation study of the co-production processes in a community-based mental health project at the London Borough of Wandsworth. The evaluation sought to describe actions, changes, and functions that brought about a co-productive way of offering Improve Access to Psychological Therapies (IAPT) services in this locality. The study aimed at producing transferable knowledge about a novel model of public service provision, which was developed by Wandsworth Community Empowerment Network (WCEN) in association with the South West London and St George's Mental Health Trust. The 'Wandsworth Model' entails canvassing partnerships with local faith-based and other community groups, who got engaged in co-producing responsive mental health services, in an attempt to address issues such as access and effectiveness of service delivery.

The study applied a participatory research approach to capture the co-production processes that took place in establishing the partnership between the mental health services and WCEN and the impact of such initiatives in reaching out to local BME communities. Our main method of gathering evidence was narrative interviews which were conducted with key informants from the three groups involved in delivering co-produced services: IAPT professionals, WCEN workers, and community/religious leaders. The thematic interview areas were: the participants' involvement in the co-produced services, views about co-production, benefits and challenges of co-production for all stakeholders, and suggestions for improvement.

The findings for this study suggest that co-production can be very rewarding for both public agencies and communities, if supported and implemented with a view to empower people instead of making false economies for the welfare services. The ultimate goal should be that service users become partners in managing their own health however this is a major shift that requires a lot of experience and commitment in the co-production of services and, perhaps, it can only be possible when systemic barriers at community, public agency and state levels are brought down. Nonetheless, the 'Wandsworth model' of co-production appears to be a promising approach and should be further explored and supported to achieve its full potential.

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1. INTRODUCTION

1.1. BACKGROUND

Significant changes in UK governmental policy in the last few decades radically shaped mental health services by a progressive focus on service user participation, empowerment, and greater emphasis on a social model of mental health care (Department of Health, 2011a). Nonetheless, these reforms have largely run their course and although in some cases they have produced important improvements, services are currently faced with an unprecedented set of challenges: increasing demand, rising expectations, seemingly intractable social problems and reduced budgets (Allen et al, 2009). As a way forward, the notion of partnerships and co-production has been introduced in the latest public services policies, suggesting that the key to reforming public services is to encourage users to design and deliver services in equal partnerships with professionals. There is a wider acknowledgement that users of public services are a hidden resource that can be used to transform services and strengthen their neighbourhoods at the same time (Boyle and Harris, 2009).

This report presents findings from an evaluation study of the co-production processes in a community-based mental health project at the London Borough of Wandsworth. It is argued that co-production has the potential to deliver a major shift in the way we provide health, education, policing and other services in ways that make them much more effective, more efficient, and therefore more sustainable. As a relatively new idea, there is no agreed definition but Boyle and Harris (2009) attempt to define it as follows:

> *"Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change."* (p. 11)

For mental health services, this approach offers a fertile ground to encourage effective partnerships when tackling social and health inequalities (DH, 2011a, b). Community-based mental health projects have taken on board these ideas and there are some examples of good practice such as projects set up in the Wandsworth area of London. As with all groundbreaking innovations, co-production projects are in need of reliable evidence which will be used for strengthening their position and promoting this practice in the health and social care sector. Such evidence should go beyond the medically-focussed assessed outcomes and should recognise the impact on the communities and the promotion of alternative ways of practice (Needham and Carr, 2009).

A crucial issue when evaluating community-based mental health projects is the lack of appropriate conceptual tools to study holistically the experiences of the community. There is need for holistic conceptual approaches such as the ecological approach to study the human experience acknowledging the wider political, social, historical, economic and spiritual realms of their reality (Trickett, 2009).

Also, in order to find appropriate ways to evaluate outcomes of such projects there is need to move away from traditional biomedical understandings of mental health and adopt a broader understanding of wellbeing that takes into account the socio-economic context in which projects operate. One such approach is Liberation Psychology (Montero and Sonn, 2009, Nelson and Prilleltensky, 2005) which has a focus on social exclusion of oppressed groups, social transformation as a way of addressing mental health issues of these groups and participatory methods as a way of working. By adopting this approach, we can consider a framework of Community Cultural Competence (Garcia-Ramirez et al, 2010) which permits the experiences of Black and Minority Ethnic (BME) groups and respective professional responses to be viewed as a psychopolitical empowerment and self-construction process by which BME service users transform both structural conditions and themselves.

The framework of the Community Cultural Competence is promoting among community providers (see Figure 1 below):

- **at intrapersonal level**, the development of critical thinking, through reflection and evaluation, opening the door to new interpretations of oneself and one's

activity. It also implies the promotion of a new professional identity, which means being conscious of different cultural groups and one's own cultural background, valuing and respecting diversity and recognizing inter-group heterogeneity.

- **at the interpersonal level**, new roles to empower personal and political change in communities, e.g.

  Instigators of change: to bring about the development of critical thinking about opportunities, rights and resources.

  Mediators: To promote social participation and creating cooperation between communities living together and striving to achieve legitimacy.

  Facilitators and advisers: To support service users in their actions to achieve citizenship and social rights.

- **at the collective level,** it implies the carrying out of socio-political actions, designing and establishing agreements with community leaders and recognise the users/customers as active political agents, thus promoting the construction of a fair, multi-cultural society.

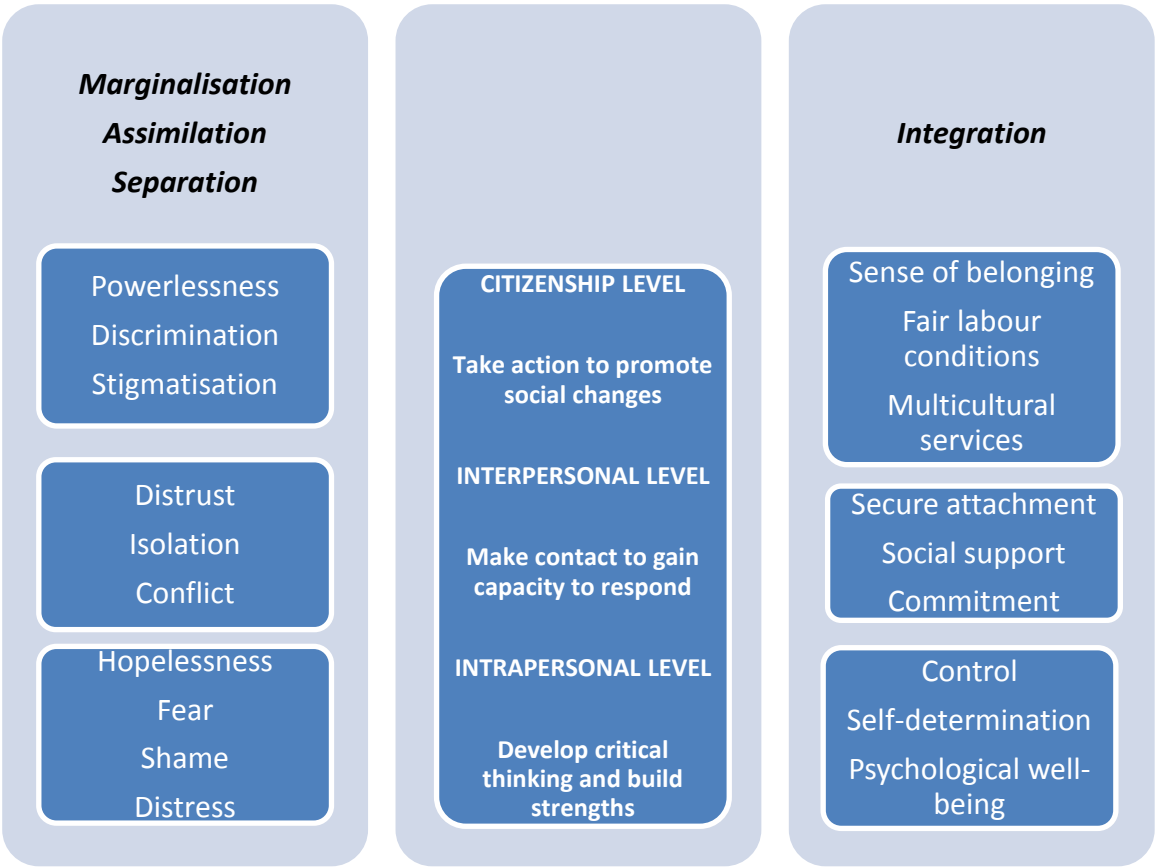

Figure 1 *Acculturative integration as a psychopolitical process (Garcia-Ramirez et al, 2010)*

1.2. THE CONTEXT OF THE EVALUATION

The national programme to Improve Access to Psychological Therapies (IAPT) was funded to enable 800,000 additional people to access National Institute for Clinical Evidence (NICE) recommended therapies for anxiety and depression across England between 2008 and 2011. According to the IAPT's website (http://www.iapt.nhs.uk/about-iapt/ accessed 5 November 2012):

> *"It was created to offer patients a realistic and routine first-line treatment, combined where appropriate with medication which traditionally had been the only treatment available. The programme was first targeted at people of working age but in 2010 was opened to adults of all ages."*

The programme was concerned with raising standards in the recognition and treatment of people who suffer from depression and anxiety disorders and it was at the heart of the Government's drive to give greater access to, and choice of, talking therapies to those who would benefit from them (DH, 2011a,b) through:

- provision of an appropriately trained workforce,
- delivering therapies to specific quality standards,
- routine monitoring of patient reported outcome measures,
- defined care pathways (characterised by a stepped care model) and
- flexible referrals routes (including self-referral by potential patients).

The IAPT programme aimed to extend the benefits of improved access to talking therapies to a wider range of groups such as: children and young people, those with physical health long-term conditions (LTCs) and mental health issues, those with severe mental illness (SMI) or other under-represented groups such as older people from black and minority ethnic communities.

A significant driver of the initiative was also the expected significant financial benefits as a result of this approach; the NHS predicted that it could save up to £272 million and the wider sector would benefit by more than £700million (from the IAPT website, http://www.iapt.nhs.uk/about-iapt/ accessed 5 November 2012).

Cognitive Behaviour Therapy (CBT) was selected as the first therapy to deliver and a target of 3600 extra therapists was set to develop an enhanced and to some extent an entirely new workforce. The role of a case manager/low intensity therapist or coach was used as the prototype for the practitioner who would deliver low intensity, CBT based, interventions, subsequently to be called the Psychological Wellbeing Practitioner (PWP).

1.2.1. IAPT Services at Wandsworth

The Wandsworth Psychological Therapies and Wellbeing Service was launched in September 2009 as the IAPT initiative. This was preceded by a scoping study into the feasibility of achieving IAPT outcomes for people with anxiety and depressive disorders from BME communities with specific reference to Bengali, Urdu, Tamil and Somali (BUTS) speaking communities in Wandsworth (see Loewenthal et al, 2009) funded by NHS Wandsworth and SW London and St George's Mental Health Trust.

IAPT services adopted the co-production model by working with local communities to gain access to '*hard to reach communities*' across three main clusters: Wandle, Battersea and Putney and Roehampton (for a map of IAPT community sites see Appendix A). Therapy was provided by a team of Low and High Intensity Therapists, throughout the borough who were recruited to reflect the ethnic diversity of the local population. Hence, a total of 27 therapists were employed, 17 of them from BME backgrounds and with a total of 7 languages spoken between them. Raw data collected by the service for the period between September 2009 and December 2011 indicated a significant increase of self-referrals to IAPT, especially from co-provider community sites as well as an increase of BME people entering the service (from Wandsworth BME IAPT Performance Reports 2009-2011). IAPT Performance Reports, produced quarterly by IAPT staff during the period 2009-2011, contained workforce data summary, data about the source of referrals to IAPT services, some demographic data about the people entering the services (e.g. gender, ethnicity), data about people completing treatment, 'moving to recovery', and, more lately, information about co-provider site usage.

Wandsworth IAPT Performance Reports: September 2009 - August 2011

The information presented here is purely for indicative purposes and provides contextual background to the analysis of our findings from the interviews. The data extracted from the aforementioned Performance Reports indicated an increase in access to IAPT services. For the period September 2009 - August 2011, a total of 5715 persons entered the service. Although ethnicity was recorded - 12.82% were identified as being from a BME background and 39.94% from a White background – there was a significant number of missing or not stated data (47.24%). The majority of people using this service were women (66.5%). During our analysis of the data in performance reports we noted that statistical information was not recorded consistently and that there were many cases of missing data, therefore it is difficult to assess accurately the extent of the increase in BME people accessing IAPT services.

Breakdown of referrals

In terms of how service users came into contact with IAPT services, Table 1 presents the sources of referral at two points in time. These figures highlight that there has been a shift in the source of referral from General Practitioners (GPs) to self-referral. In relation to the former, in the period between September 2009 to August 2010, more people were referred by their General Practitioners (GPs) (N=4541), than the period between October 2010 to August 2011 (N=862). This was followed by an increase of self-referrals; in the period between October 2010 to August 2011 more people self-referred (N=2408) compared to the preceding period September 2009 to August 2010 (N=730).

Table 1 *Breakdown of referrals* by source between September 2009 and August 2011*

Source of Referral	Sep'09-Aug'10	Sept'10-Aug'11
General Medical Practitioner (GP)	4541 (83.12%)	862 (23.13%)
Self	730 (13.36%)	2408 (64.63%)
Local Authority Social Services	5 (0.10%)	4 (0.11%)
A&E Department	6 (0.11%)	-

Other clinical specialty	152 (2.80%)	419 (11.24%)
Medical outpatient services	11 (0.20%)	1 (0.03%)
Community/Practice Nurse/Health Visitor	2 (0.03%)	-
Other **	15 (0.27%)	32 (0.86%)
Employer	1 (0.02%)	-
TOTAL	**5463**	**3726**

* Referrals are different to number of people entering the service

** The 'Other' category includes: Job Centre Plus, Ingeus, Resource/Community Centre, Voluntary Sector Organisation

N.B. Specific Community organisations were not added to the data base until later in 2011, therefore self-referrals would account for many of those being referred from community organisations.

In the first reporting period (September 2009 – August 2010), Black/Black British people accounted for the highest number of referrals within the BME population, either via their GPs or self-referrals. GPs were also the most common referral route for all BME groups as well as for 'White British' population, whereas self referrals were made by only 605 'White British' and 125 BME people.

In the second reporting period (September 2010 – August 2011), all ethnic groups presented the same reverse trend of self-referrals being more than the GP ones. It is also worth noting that, during this reporting period, the 'White Other' group had the highest referrals rates of both GP and self-referrals. This group is likely to include Eastern Europeans, which may be a rather vulnerable but frequently hidden minority group when considering access to physical/mental health service

1.3. AIMS OF THE EVALUATION

In this evaluation, we sought to describe actions, changes, and functions that brought about a co-productive way of offering IAPT services in Wandsworth. The aim was to produce transferable knowledge about the 'Wandsworth Model' (WM), which was developed by Wandsworth Community Empowerment Network (WCEN) in association with the South West London and St George's Mental Health Trust (for

additional information about WCEN and a list of WCEN's community partners see Appendix B).

This model entails canvassing partnerships with other local faith-based/other community groups which became involved in co-producing responsive mental health services, while at the same time attempting to address issues such as access and effectiveness of service delivery.

Key components of the WM are (from WCEN Co-production and the Big Society flyer):

a. **the *methods*** in which local relationships are developed to bring community and faith based organisations together, and co-production opportunities are identified;
b. ***the key propositions*** which entail communities as experts and knowledge holders of area, with the State as enabler of social action. The latter being the complementary action between the State and society;
c. ***the practice*** of actual collaborative work between the various partners in the Wandsworth project; and,
d. **the *challenges*** inherent in working with diverse communities such as those that are out-of-reach, public agencies' figures connecting with these communities, and enabling conversation to take place.

The purpose of our project was to pilot a participatory evaluation process exploring the impact of community-based mental health projects initiated in the Wandsworth area in collaboration with the South West London and St George's Mental Health Trust (SWLSG) and the Wandsworth Community Empowerment Network (WCEN). The focus of the evaluation was the project undertaken by WCEN to improve uptake of Improving Access to Psychological Therapies (Wandsworth IAPT) services by Black and Minority Ethnic and social excluded groups.

In particular, the questions that this pilot evaluation sought to address were as follows:

1. How can associations between public agencies and community groups create co-production opportunities?

2. What are the social and economic values underpinning the Wandsworth Model of service provision?
3. How is the new learning from the co-production processes being transferred to public agencies and community groups?
4. What are the benefits of the Wandsworth model for public agencies, community groups and the wider communities where co-produced services are delivered?

1.4. EVALUATION STRATEGY

For the evaluation we decided to adopt a participatory research approach, which would allow us to assess the impact of co-production processes in the partnership between the mental health services and WCEN as well as the effect of such initiatives on improving services for the local BME communities. The adoption of a Participatory Action Research (PAR) approach enabled us to work collaboratively with WCEN, professionals and community leaders.

Our main method of gathering evidence was narrative interviews which were conducted with key informants from the three groups involved in delivering co-produced services: IAPT professionals, WCEN workers, and community/religious leaders. These groups were involved in the process of initiating, enabling and realising community-based mental health projects such as the collaboration with IAPT clinicians delivering services in the area. This particular method envisages a setting which encourages and stimulates informants to tell their story about the significant developments in the implementation of the Wandsworth Model (WM). This approach elicits a less imposed and therefore more valid account of the informant's perspective (Bauer 1996). Due to time and financial limitations, it was not possible to interview users of IAPT services or their carers. We acknowledge that this is an important perspective in order to understand fully the impact of co-production in mental health service provision.

Ethics approval for the conduct of the project was obtained by the Research Ethics Committee of the Faculty of Health and Social Care Sciences, Kingston University and St George's, University of London.

1.4.1. The Sample

Due to the exploratory nature of this evaluation study, we adopted a purposive sampling strategy. With the assistance of WCEN, a number of key informants were identified from the three target groups for a narrative interview. Informed consent to participate in the study was obtained prior to the interview. In total, we interviewed 14 people: 4 community organisation leaders in co-provider sites, 4 psychological wellbeing practitioners,1 community development worker, 2 WCEN staff, 2 service managers and 1 service commissioner; in Table 2 below we present their role, gender and assigned code. In the discussion of findings we will use assigned codes when presenting direct quotes from the interviews.

Table 2 *Description of participants in the study*

CODE	ROLE	GENDER
PWP1	Psychological Wellbeing Practitioner	Female
PWP2	Psychological Wellbeing Practitioner	Female
PWP3	Psychological Wellbeing Practitioner	Male
PWP4	Psychological Wellbeing Practitioner	Female
CDW1	Community Development Worker	Female
COL1	Community Organisation Leader – Co-provider site	Female
COL2	Community Organisation Leader – Co-provider site	Female
COL3	Community Organisation Leader – Co-provider site	Male
COL4	Community Organisation Leader – Co-provider site	Female
WCEN1	Wandsworth Community Empowerment Network staff	Male
WCEN2	Wandsworth Community Empowerment Network staff	Female
SM1	IAPT Service Manager	Male
SM2	IAPT Service Manager	Male
COM1	Mental Health Service Commissioner	Male

1.4.2. Analysis of Data

Interview data was digitally recorded and transcribed verbatim, with the exception of three interviews where notes were kept by the interviewer. The data was analysed for content. For the purpose of this analysis a coding scheme was developed, intended to capture the diversity of participant views to the evaluation questions we had posed.

2. FINDINGS

Findings are presented by main thematic areas which follow the interview schedule used to discuss the experiences of co-production with the participants (see Appendix B). The thematic areas of the interviews were: the interviewee's involvement in the co-produced services, views about co-production, benefits and challenges of co-production for all stakeholders, and suggestions for improvement.

2.1. WHAT CO-PRODUCTION MEANS TO STAKEHOLDERS?

Co-production is generally understood to be a process whereby professionals and citizens or community groups come together to develop and deliver services (Needham and Carr, 2009). We have not directly assessed the meanings of co-production, but sought the views of participants on this. The way in which they talked about co-production enabled us to construct a typology of the meanings thereof in this sample. On the one hand community groups perceived co-production as a process for designing and delivering a service for and within the community, whereas service providers seem to have a much narrower view of this and saw co-production as providing a service in a community space. As one respondent stated:

> *"…there were huge disagreements, part of the disagreement were their* [mainstream service providers] *…notion of co-production in the beginning was – we will just use your building and come in for two hours and provide the service and leave."* (CDW1)

However, as it will become clear in the discussion below this view seemed to change as the IAPT project developed.

Overall, co-production was construed as a process that involves designing and delivering a service utilizing social capital for the benefit of everyone, sharing risks and responsibility across the community, building and sharing skills and knowledge.

A key feature of co-production was the metaphor of '*sitting around the table*' that was echoed in most of the interviews. As one participant stated:

> *"…it is about sitting around the table talking together, having honest and open discussions."* (SM2)

There was a view that this '*sitting around the table*' required time, talking together as equals and an awareness that there would be different and often competing perspectives around the table. For example, one respondent talked about being equal, whilst another talked about people coming from different perspectives as the 2 quotes below illustrate:

> *"I think because we had confidence and that ability to put our feelings across…we could talk on a level that was equal."* (COL1)

> *"But we have responsibility as professionals and with those responsibilities we sit at the table in a slightly different place to the service user and carer. They're not all the same sitting round the table.*" *(S*M1)

Co-production was construed as a process of reaching common ground and a shared understanding of what is required and what is to be achieved. Participants also considered acceptance and tolerance of differing perspectives as a crucial element in developing joint solutions. It was also acknowledged that this process requires time to reach a common and agreed understanding:

> *"It took six months of talking and listening and giving groups an opportunity to express themselves. I fear an honest approach was needed, i.e., tell them that the bad experiences was not good, in fact it was unacceptable."* (SM2)

The quality of the dialogue was therefore perceived as an important dimension of the process.

Co-production was also viewed as a transactional process, from which all participants benefited. There was a perception that there was a transfer of knowledge, skills and expertise from the communities to mental health services and vice versa. It can therefore be construed as a reciprocal process:

> *"And for the whole system to learn from that, it's kind of getting both things more permeable, so that there's a bit of public sector stuff that gets into the communities and a bit of community stuff gets into the public sector."* (PWP3)

A common view was that co-production is a '*negotiated activity*' that comes with challenges, particularly due to the negative perceptions that the communities have of mainstream services. Moreover, there was a strong perception that power plays a significant role in how co-production is understood. Interestingly, power was seen to be held by the statutory sector and pertained to resources, policies and decision-making. However, there was no acknowledgement that community groups and organisations also have power and agency, e.g. local knowledge, greater understanding of local need, the ability to be culturally sensitive and responsive, and visible and acceptable leadership. Power could also conflict with co-production, especially when there was a duty of care involved, such as the use of power under the Mental Health Act.

> *"I suppose at the end of the spectrum in mental health we have a duty under the Mental Health Act and those statutory duties give us the power to detain somebody against their will…and even at that stage we can do it with some principles of co-production and we can think how we ensure people have their rights and that they're given information."* (SM1)

Co-production was seen as having immense potential for achieving positive and lasting change:

> *"Co-production is an opportunity to engage with communities in a different way."* (SM1)

"Co-production is an ideal to create a democratic and better society." (WCEN1)

2.2. HOW DOES CO-PRODUCTION WORK?

As noted above, the concept of co-production has emerged in recent years as a general description of the process whereby service users work alongside professionals in order to make public services more effective. In this section we describe the aspect of this process that is related to the Community Activity that individuals, groups, organisations and networks engaged in to build Community Capacity to deliver a public health intervention (e.g. IAPT) in Wandsworth. We therefore highlight the participation in actions of communities of interest in Wandsworth, which are based on a shared purpose to improve the mental health and well being of individuals in this locality. This was achieved through Community Capacity Building and through the use and development of resources existing in the fabric of Wandsworth social structure (e.g. Social Capital), and the Community Activity facilitated by such structure. We illustrate this by describing the types of activity communities have engaged to build both social capital and community capacity.

2.2.1. Building Social Capital

The concept of social capital helps us to simplify the complexity of the social world under investigation. Social capital, therefore, are the social resources that are ingrained in network connections, reciprocity norms, and social trusts that facilitate participative transactions that allow individuals, groups, and the community at large to cooperate and coordinate activities in achieving mutual goals for mutual benefits (Robinson and Meikle-Yaw, 2007). For this evaluation, it assists in understanding the structures and processes that took place in the implementation of a co-production approach in the delivery of services. We are now going to describe the types of activity communities utilised to build social capital.

Building relationships

WCEN had a pivotal role in forging a structure of communication between co-production partners. It developed this through the canvassing of support for the co-production initiative from existing groups and organisations already affiliated to WCEN. Initially members of WCEN informed networks members of a proposal from the Mental Health Trust Directorate. The proposal was to employ local people and train them to become psychological therapists in the mental health early intervention, IAPT. These relationships were important because they linked public services and community organisations together and opened up opportunities to initiate conversations. Practitioners in particular talked about how relationships were crucial to facilitate communications among different partners, and particularly providing a chance to clarify and be transparent about what engaging with co-producing IAPT service would entail for different parties:

> *"We, being the Community Empowerment Network, our network is made up of community sites. We then began a conversation with them* [Trust] *about where do you place these* [your clinical services] *in community sites."* (WCEN1)

> *"What we're actually able to do is get around the table and talk together and be very honest and open with each other. So again, the sort of ... the mist is cleared, there is clarity in terms of what the purpose is of one side, and what the needs are of another and how these can be met ... has opened up some new dialogues and opened up some new possibilities of thinking."* (PWP3)

> *"The fantastic relationships that have been built. I think there's a really, a very transparent, open, honest dialogue between, I'm talking about our service in particular, and community groups, which have been really facilitated,* [....] *particularly by the relationships have been really based on mutual respect, and I think that's facilitated things."* (PWP2)

Co-production relationships provided the context for the creation of linkages to bridge diverse communities and public services and initiate working relations across different 'stakeholder borders':

> *"So in a way, that they* [WCEN] *came in, like in the middle, like kind of link the NHS and the Temple so they can work together."* (PWP4)

> *"We're a faith organisation, we're not a health organisation, so building up that relationship."* (COL3)

Relational linkages enabled practitioners to link-in existing networks and take part in events they organised such as those taking place on the Mental Health Day. Linkage-in provided a channel for information and ideas to flow across the network structure, from formal institution to individuals and vice-versa. Linkage-in events provided occasions for stakeholders to take stock of own practices, reflect on them, and re-evaluate them.

> *"Healing our Broken Village provides a forum in which the community, a variety of individuals, stakeholders within the community can come together with senior staff from the Trust and actually have those kind of conversations and agree, disagree, challenge, think, re-think, talk, laugh, cry. And then come back with something that, 'OK, this is what we've got from all of what we've heard, let's see how we can refine that so that it's something that works for everybody'* [...] *That initial contact provided an avenue where those that want to and are committed to providing mental health and wellbeing services, are able to meet those that are the recipients and users and the consumers of mental health services. And we can actually see very clearly, as we sit together and talk together, that we're missing the mark."* (PWP3)

Building relationships was an important outcome in the process of building social capital, on which some participants thought the success of co-production depended upon:

> *"Good relationships with community groups are important for the success of co-production. It is a slow process."* (CDW1)

Other participants commented on the lengthy process of building relationships, stating that it was a time consuming endeavour which could not be done 'in haste' (a theme that has already been discussed earlier):

> *"I believe that it is all about relationships and it is all about building these relationships in the community and that takes time. And it takes a lot of trust and it takes a lot of effort."* (PWP1)

> *"Again, by virtue of a relationship, I think you can't rush relationships."* (PWP3)

Relations of trust

The notion of trust figured strongly in the participants' narratives about the early negotiations with public services and developing a relationship with them. Particularly, trust was a necessary feature to develop a working relationship between community leaders and public services, but also to enable service users to engage with the services.

Getting to know each other was part of the process of building trust between parties, as a community leader said:

> *"IAPT had to get to know the church, who we are, what we did and so on and so forth, and we in turn had to get to know IAPT as a service."* (COL3)

Trust between co-production partners was a crucial element to deal with tensions in the early negotiations between public service agencies and community leaders, who were mindful of the 'inherent risks' of bridging relationships and establishing linkages with partners outside of the community, who might have had a different ethos. In particular, community leaders had to overcome their distrust of mental health services that had acquired a negative reputation among black ethnic communities:

> *"And so I think we had to overcome perhaps a bit of our distrust, not distrust, apprehension I think would be a more correct word* [...] *And being located at Springfield, Springfield Hospital, in some ways sort of flagged up some red lights because Springfield Hospital mental health, some negative reports, and making those leaps, which were understandable but wrong, is this another mental health thing that is going on?."* (COL3)

Similarly, relations of trust were seen to be important for service providers to reach out to traditionally marginalised groups:

> *"BME have strained relationships with the statutory mental health services. IAPT is a fresh attempt really to engage with communities who have traditionally been very suspicious, for often very good reasons, of statutory services."* (SM1)

Trust was also the outcome of social capital in the context of faith-based communities. The trustworthiness that church members placed on the church leadership engendered a '*values ethos*' among them; this shared value created a stronger bond of trust and reciprocity thereby giving church members the confidence, they lacked, to access services:

> *"And I think the trust that they (church members) would, and do have, in our leadership, gives them the confidence to access services. And I think the link I think is very important between the church and the service provisions. So I think for the service user, being able to self-refer, being able to know that if they belong to a faith group as well, that their leaders are also giving the green light to the service as well. Sometimes, you know, when an individual is instructed or guided to access a particular service, they have no other corresponding means of being able to say: 'Well that's an OK service', they just trust the word of the professional."* (COL3)

Trustworthiness inbuilt in the process of service delivery is a model of co-production that community leaders thought was the answer to open up access to 'reluctant' service users seeking help from mental health services:

> *"And I think as a model, you know, it works well if people, if it is known as a general exchange between the participant. It's really important because it's about trust building as well."* (PWP1)

> *"...and that the person who is offering the IAPT service is somebody that they trust."* (WCEN2)

"X is an attendee at the local temple where she provides the service. So the trust is built in to the process." (WCEN1)

In addition to this, a number of participants saw the association between the trustworthiness of leadership and the place where the service was provided as important (e.g. the church or temple). Places of worship were thought to provide a safe environment for 'reluctant' service users as this would remove the stigma associated with accessing mental health services in public buildings:

"There's a service here at church that does exist, whereby in a safe environment, non clinical environment, that you can access it. It minimises potentially the stigma that's attached to individuals accessing mental health services, regardless of the continuum that you find yourself on. Having the service located at a trusted location I think is good." (COL3)

"And the idea of having the sessions here (Temple) was very important because talking to our devotees [...] they found it difficult going into hospital because unfortunately the stigma for mental health is still very prevalent." (COL4)

The network structure in which community organisations operated was in itself a kind of capital that created for certain individuals or groups an advantage in pursuing their work. There was a perception that better connected people enjoyed higher personal and organisational returns.

"I have excellent relationships with the community centres that I work from. And that has been so enriching for me. So that NTA for me is like a second home now. So relationships are formed with the people there. I don't attend church there but I've gone to services there, I get involved in extra things there now […] *being part of a community really, whether that is and how being part of that enables me to contribute in a more fulfilling way."* (PWP2)

"But if there are any new issues, and Y [from WCEN] *will always sort of keep us informed of new initiatives that are coming through. And importantly as well, what he's done is, through the WCEN, we've got contacts with other places of worship* [...]. *And because we had WCEN with us we were able to*

get this (off the ground) so quickly [...] *would never have been able to get that many important people together in one room at one time to be able to, and that's purely due to Y* [from WCEN]*."* (COL4)

Shared norms

The collective value emerging from networks connections, and the inclinations that arose from these networks to do things for each other (norms of reciprocity) was an important aspect of building social capital, which was a key feature to initiate Community Activity aimed at co-producing IAPT mental health service. What underscored these narratives was a commitment towards social change aimed towards opening access to otherwise marginalised communities, towards changing the way resources are used within the community, and towards changing the way in which public agencies and communities organisation work together to benefit the serving community/ies:

"Part of the sort of bidding for IAPT was very much about the community groups being involved in that and supportive of that. And also, very much about sort of trying to find ways in which to address some of the particular issues and experiences that might give rise to mental health problems that some BME groups might have." (PWP2)

"IAPT is fresh attempt really to engage with communities who have traditionally been very suspicious, for often very good reasons, of statutory services. Another opportunity to engage with those communities in a different way and open up access to psychological therapies which were largely exclusive to middle class communities." (SM1)

"...the whole idea of co-production is that it's a propellant in joint working, it's a shared understanding of how to provide a service that's benefiting the community. And that the local health authority and the church has a vested interest in making sure that this service is on offer to the community." (COL3)

Drawing on existing local resources

Drawing on the human resources and specialised skills ingrained in network connections were central to build the social capital that enabled community organisations to take on the responsibility to deliver IAPT services. In particular, having human capital - e.g. professional skills - enabled some community organisations to have leverage when negotiating with public services about the configuration of the service:

> *"Bringing remarkable skills and talent of every-day people, to add value to public services. There are professionals in the community who have the skills to provide a service that the NHS cannot do."* (WCEN1)

> *"The tools and resources are in the community- they need to lead with support where needed* [...] *because we had the resources in-house basically; within the community."* (CDW1)

> *"At the first meeting with NHS it was a bit of a shock. First of all because it was probably one of the first organisations that had actually had people more qualified within their community, who could tell them, look this is not what is going to be useful here, this is what we've tried and this is what we know it needs to work."* (COL4)

Having a strong skill based membership gave community organisations the '*confidence and the ability*' they could put their ideas across and negotiate with public services on their own terms. Talking on '*a level that was equal*' gave community organisations bargaining power.

2.2.2. Community Capacity Building

Community Capacity Building is the shared responsibility that drives the action of local stakeholders groups to co-produce services. These actions increase partnerships and social relations which function as channels of communication within and between local stakeholder groups.

The activities that took place to build the infrastructure to deliver IAPT program were: using existing skills; enhancing community capacity, competencies and skills of individuals; training a network of Psychological Wellbeing Practitioners; building partnerships and organisational environments (to help sustain programs and '*gains*' or positive outcomes - as illustrated in the Section 2.2.1.); building support capability in communities and systems (to ensure appropriate responses to new problems).

Skill building

Some community organisations were more structurally ready than others to delivery IAPT services. This was due to the fact that some of them were already engaged in providing some form of psychological relief to refugees suffering from Post Traumatic Disorders in their organisation (e.g. Temple). Having skilled and experienced professionals amongst their networks also enabled some organisations to participate in the design of a mental health service that was sensitive to the needs of the local population:

> *"Because we had ... my husband here who was medically qualified, we had psychiatrists here who knew what they were talking about, they were able to say specifically, this is what's going to help in this place. And we weren't scared to say, no that's not going to work here, this is going to work here* [...] *Because for us, we knew what our people needed and we knew that the standard form of psychological therapy would not work in this case, because there was so much background history that I was involved with."* (COL4)

> *"We used the expertise that exists locally to build a service that should, I think should reflect what people actually need and will make a difference."* (PWP2)

Other community organisations could draw on individuals who had language skills, or inter-personal skills and knowledge of Black Caribbean culture. Such assets were thought as important to enabled them to offer a culturally competent service, to target the local community:

> *"So to have people who were, the psychotherapists who were Tamil speaking was so important to have. Luckily in Merton they had S, who'd already started on a voluntary basis there, so she moved into IAPT as well. So we've got one in each now, which is fantastic."* (COL4)

"So through the pastoral, if you want, the pastoral work has been the doorway through which I have entered and been exposed to support, coaching, mentoring, therapy of a variety of sorts, even though we wouldn't necessarily in our setting, we wouldn't call it therapy. It would be helping or supporting or encouraging or exhorting, reasoning is another word that's very appropriate within our black Caribbean tradition. So it would have been through those things that I had a grounding in these matters." (PWP3)

Those community organisations that were not structurally ready to deliver IAPT programme had to build the capacity to deliver this service, therefore the capacity, competencies and skills of volunteers had to be enhanced, together with the formal training of a network of practitioners:

"I am training CBT therapists and they come from a very different part of the world. They have their own challenges but BME is not one of them." (PWP1)

"We decided to try and create something that would help us to train our volunteers to cope with the situation [...] *so we brought her* [the PWP] *in to do a workshop for us to help train up our volunteers to help our devotees in a greater way* [...] *we trained the volunteers both through the mental health first aid course that Wandsworth did for us, and through the training that M* [the PWP] *did for our volunteers."* (COL4)

"Myself and X, we did some training for some individuals that are going to be working in prisons, with people who have had short sentences and are coming back after being [...] *in prison. So it's normally not major criminal offences, but it's enough for them to maybe have lost their job, for relationships to have been fractured and so on. So part of their work is to support these individuals, help them get, if they need benefits, sort out benefits, housing and so on."* (PWP3)

Furthermore, skills building was about enabling community leaders to develop professionally through equipping them with theoretical knowledge about therapies or through acquiring a formal degree in mental health:

"Enabling those community pastors to think differently and think, again, about some of the dilemmas that they're facing with some of their congregation." (SM1)

"... it was a combination of practice, as well as education. So in University, I think it was three days a week, in clinic two days a week. And so I thought, that's ideal and the fact that I'm unemployed means that I get paid on study, I can do this. And there began the process of qualifying. Because I hadn't done a University degree before, I had to, if you want, qualify myself for the programme." (PWP3)

Developing support

Developing the availability of practical support to enable the development of skills and structures was very important for the success of IAPT programme. Co-production community partners provided mutual support to each other:

"And we go to each other's meetings or conferences, so we support each other. And what I was really keen on, because it's worked here, I told Y [from WCEN] *that I'm happy to act as mentor for other smaller organisations, who may not have the confidence that we had to be able to talk to the authorities. So that we can help other communities to grow as well and to get the support that they need, and the specific supports that they need in that way. So we have to help each other in this way, you know."* (COL4)

Moreover, practical support from the public services was very much needed to develop the necessary skills to run the programme, while others offered their support:

"We need the NHS to continue to support it because that targeted, skilled aspect is needed […] *And so we need to recognise that and know how we can deal with that and help support. But the essential need is the support of the NHS because we don't have the skills as a resource to be able to do that."* (COL2)

2.3. WHAT ARE THE BENEFITS AND CHALLENGES OF CO-PRODUCTION?

There were a number of benefits as well as challenges that all interviewees identified in the process of co-production, at the intrapersonal, interpersonal and community levels. Namely, all participants discussed issues that affected service users personally, in relation to their communities and service providers and in relation to their ability to be part of the system as main stakeholders. These issues are discussed from the perspectives of community leaders, practitioners and service managers and power dynamics are identified as a major influence in the way various stakeholders perceive them.

2.3.1. Benefits for Service Users

Although we did not interview service users or family carers, all interviewees discussed benefits for service users as they witnessed them during the intervention period or through their own interpretations of how service users were receiving this new type of services.

Trusting the services

Community organisation leaders, WCEN and community development workers, all recognised the benefits accrued by service users in co-producing services. Not only did participants view relations of trust as necessary to build social capital (see Section 2.2.1.), but they thought that service users would feel more confident to access/use a service that was currently provided in a safe, trustworthy environment they were familiar with:

> "*One person said* [to me] *"I feel safer coming to the temple to see the therapist. When I go to see the NHS, I think they will call the police and send me back. It's given me peace, clarity and ability to focus*." (CDW1)

> "*For service users I understand that there is a benefit there and that they are feeling more able to get on with their lives.*" (WCEN 2)

> "*When such a service is provided, and we are a provider site as such, it gives the service users, community, such confidence.*" (COL2)

Feeling understood and sense of belonging

Similarly, the feeling of being better understood and a sense of belonging were identified as major gains for service users. This was made possible because services were delivered in locations which people felt connected with in terms of their cultural/religious identity, and a place where they could find support and empathy:

> "*Because they get a sense of belonging. They feel they will be understood, not just language wise, but as to where they come from, what the real issues might be. They probably feel understood more.*" (COL2)

Familiar environment

A significant benefit of coproduced services was the familiar environments where services were delivered. This was thought to be important for service users to feel safe and comfortable but it was also crucial in order to deal with the stigma of mental illness as these community locations were part of growing up in this community and they were associated with everyday life activities across generations instead of being clinical, impersonal places where mental health services were usually delivered:

> "*And having it in an environment, which is non medical, is non scary in that sense, for a lot of devotees who come here, this is their home. They'll be kids who've, because we've been here for so long, they have been kids who have been born and brought up here, so for them this is their second home. And to be able to have this facility here is just precious, really very precious, because for them it's a safe environment and it's a place where they feel comfortable and able to give of their own in that sense, rather than the pressures of, you know, time or other people there or that clinical, you know, the clinical atmosphere. It is very difficult for some people to go there.*" (COL4)

Feeling empowered

The fact that community organisations were able to take part in the provision of services was also perceived as empowering for the communities and would have influence in younger generations to view themselves in a positive manner:

> "*The benefits would be great because up until now, the community was still hung up about migration, you know, the back home syndrome. And it was used to that colonial model of, you know, being given to. It's now our younger*

generation that's growing here and they feel empowered and they feel they have a role in society. And so in that way, having such services as part of the norm would be very good for service users. So we're over that migration period now and ready to feel empowered and to give and to be able to take at that level. They're ready to be, ready to participate in our state, in being part of the community." (COL2)

Tackling stigma of mental illness among BME communities

Delivering mental health services in the community also resulted in increased awareness of mental health issues and helped communities to address stigma and preconceptions about mental illness. It also helped people to 'normalise' mental illness as part of life. This was recognised by both community leaders and service providers:

"*Also this aspect of just de-stigmatising the whole thing. We had, through the NHS, we ran a mental health first aid course here as well, which was fantastic, and really helped us to understand, look for signs and symptoms and other aspects. And it helped us to, gave enough information so that we can help if we see anybody going through a crisis or any sort of episode.*" (COL4)

"*I could say simply that it improves the wideness of these issues. I think that's good, that's one benefit for service users and their families. So they become more aware.*" (PWP1)

"*Local groups seem to be more open about speaking about mental health issues.*" (SM2)

Also, the simple fact that the location of service delivery was not identified with mental health services was very helpful for people to be able to attend these services without being labelled as 'mentally ill' by their communities:

"*I think initially when they, some of them, heard that it was at the Temple, their worry was that they would meet other people who they would know. We've kept it as quiet as possible, so people don't see them. And even if they do*

meet people they know, they can say that they've come into the Temple to pray and that's it, which is great for them." (COL4)

Building capacity of communities to deliver public health services

An important aspect of co-production is the development of social capital as discussed in the previous section. Participants, especially community organisation leaders, talked about the importance for their organisations to feel capable to engage with NHS and become co-providers by building on existing skills and developing new ones:

"*Not only do you build the capacity of communities to take responsibility for the delivery of public services. So therefore, you're sharing risk and responsibility across the whole community, but you're also bringing, you know, remarkable skills and talent of everyday people, to add value to public services.*" (WCEN1)

The catalytic role of WCEN in encouraging and strengthening community organisations in their efforts to engage with co-production was also recognised by interviewees:

"*What they have done, is they've developed within us, you know, WCEN have developed within us a confidence, that empowerment, you know, it was part of their thing but it's exactly what they've done for us. Because they've given us the confidence to know we can go on our own.*" (COL4)

2.3.2. Benefits for Service Providers

Service providers at all levels – managers and practitioners – identified a number of benefits that related to improved access to services for BME communities, increase of service uptake, greater involvement with communities, shift of professional attitudes to a more community-based provision of services and new learning taking place.

Greater involvement with communities

A major benefit for service providers was the opportunity to improve their relationship with communities and be accepted by them as a source of support. This is potentially very powerful as it changes current dynamics between mental health services and BME communities which are characterised by negativity and mistrust, a result of past oppressive practices. Nonetheless, the quality of this relationship will be determined by the will of service providers to 'take on board' messages from the community and move beyond a utilitarian approach of co-production to a true partnership:

> "*It strengthened the presence of the NHS in the community. People see the Trust in a broader light, which make them approachable and people use* [Trust] *services more.*" (CDW1)

> "*So a benefit for me, after the link with WCEN, through the IAPT initiative, is that we're able to demonstrate a relationship in action. It's the reality to it, so it gives us kudos, it gives us status, it gives us evidence of ability to work beyond the asylum, you know, beyond the gates of Springfield Hospital. We are actually out there liaising and working and trying to pick up what's happening in the communities.*" (SM1)

The significance of engaging with communities and enabling them to take 'early action', i.e. preventive actions, to address individual and social challenges has already being recognised by various stakeholders (Allen, 2011). The key role of prevention can deliver the 'triple dividend' of social, financial and economic benefits for mental health and, more generally, public services (Robinson, 2011). More importantly, this paradigm shift towards prevention and early intervention can create the opportunity for people to lead healthier lives.

Shift of professional attitudes

Managers and practitioners identified another benefit for them which related to a shift of attitudes among professionals to think 'outside the box' and engage with modes of delivery which challenge the existing status quo of power imbalance between therapists and service users, where the therapist is the 'expert' who will treat the mentally ill person in a conformist approach, determined by Western psychiatric

knowledge. Instead, having their 'feathers ruffled', professionals got inspired by the experiential knowledge of the community:

> "*We get something from WCEN, we often get challenged, we get reminded, we get our feathers ruffled. We get inspiration and it keeps us on our toes.*" (SM1)

> "*I think it's very challenging and I think that's a benefit actually, because it keeps you thinking about what would be the best way of meeting the mental health needs of the people that we're supposed to serve.*" (PWP1)

> "*I think it's very important because it enables the NHS, other services as well, any sort of Government or even police and other things as well, to be able to have contact within each different organisation.*" (COL4)

Financial gains

Co-production of service was also linked to potential financial benefits for providers as delivery of services was more targeted and efficient. The preventive value of such approach was also making savings in the long-term:

> "*Of course, it also helps the agencies, because we're in this situation at the moment where costs are being cut, demands are going up.*" (WCEN1)

> "*In the long term it's saving them a lot.*" (COL2)

In the light of the latest government cuts of health and social care funding (Humphries, 2011), this benefit bears great importance for public service commissioners and providers who are called to consider a 'new type of social contract' for the survival public welfare sector in the future. The radical new approach that public services are called to adopt is based on 'social productivity which moves away from Whitehall towards local-based collaboration, integration and shared services' (Ben Lucas, Royal Society of Arts Chair of Public Services, http://www.smf.co.uk/media/news/48bn-of-cuts-at-next-spending-review-to-get-deficit-reduction-pl/, accessed 14 November 2012).

Providing culturally appropriate services

Another benefit of this collaboration with community organisations was that service providers were able to understand better the culture-specific needs of the communities they were working with and adjust service provision accordingly. Community organisations were able to act as cultural mediators for practitioners and helped them to have a better understanding of
the service users' needs:

> "*Staff have developed skills in working with community groups and to deliver therapy in a more appropriate way.*" (SM2)

> "*I remember one of the questions that was asked was, when they dealt with Tamil patients, they found that the women wouldn't maintain eye contact. And the men would sometimes sort of cover their mouth or do these things. And we were able to explain to them, look this is a cultural thing, it's a mark of respect. They don't, you know, men wouldn't, I don't know why, but they do that as a mark of respect when they're going to somewhere who is much higher than them. So when they go to the doctors, the way they behave could be misconstrued as something else, but we understood what it was. So we were able to explain to them, even little things like that.*" (COL4)

Learning from communities

Professionals recognised that the co-production experience has benefited them greatly as they acquired a great deal of knowledge about the needs of the communities they served. This learning was challenging at times as we will discuss in the following section nonetheless, it led professionals to an in-depth understanding of the particular mental health issues of the BME communities they worked with and helped them to become better professionals:

> "*I think as a psychologist, I learn the language as well because, and improve the services, oh no I improve my understanding of the difficulties. I think it is, we talked about dialectic before, I think again it's very much about us learning more about these communities.*" (PWP1)

"*The agencies become better at what they're doing because they're learning from the communities at their doorstep.*" (WCEN1)

"*Because they realised we were from the community, we knew what our community needed, rather than going through things that wouldn't work, they thought, you know, they realised that it's important to get, use it properly to get it where it will work and it will make the best, give the best success rate I suppose.*" (COL4)

2.3.3. Mutual Benefits

In a number of instances, the gains of co-production cut across groups and cultures and touched the lives of all involved parties by improving service provision and access to care, promoting new ways of thinking and strengthening relationships between stakeholders through better communication and collaborative working.

Improved access of services for BME communities

An immediate benefit that all stakeholders identified was the improvement in the access of mental health services for BME communities. This was one of the targets for service providers (see Section 1.2.) and an expectation for community leaders who were involved in the co-production process. What helped to achieve this improvement was the 'open access' approach introduced by the service providers, which '*bypassed GPs*' and allowed people to self-refer and get in touch with the services on their own free will. The element of self-control and self-selection was crucial for this improvement of access and indicative of the challenges that service users might be facing when asking for help:

"*There was an improvement in the numbers from BME communities who've accessed the service. It helped to offer an open access service that bypassed GPs.*" (SM2)

"*One of the aims of the project was to increase access to the psychological therapy services for clients if they have come from the black and minority ethnic communities. And we have managed to do that, it has increased.*" (PWP1)

"*People have been coming to the service, huge impact of self-referral, continually higher than GPs, word of mouth seem to work, people would rather call directly.*" (CDW1)

Another gain in relation to improved access of services was the fact that a greater number of people were benefiting from mental health services, thus potentially preventing a late contact only at a point of crisis, where a number of people from BME communities were likely to experience compulsory treatment or 'sectioning' under the Mental Health Act. This benefit is also related to the need for early intervention:

"*You are enabling more people to benefit from, in our case, psychological therapies and hopefully avoiding contact with services in a crisis or avoiding contact with services through an admission under the mental health act.*" (SM1)

Mutual learning

As noted in previous section, managers and professionals mentioned that the learning that took place during the co-production process was important as it enriched everyone's approach:

"*It started with training for community groups, but also to learn from groups, such as training for staff from community groups.*" (SM2)

"*What I've learnt, well I've learnt several things, I think one of the most important things is that people do operate in silos. And I think sometimes you need to get out of your silo and I think you need to even take a step forward.*" (PWP1)

The co-production process had an influence not only on service providers or users but more generally on the community leaders who were involved as it gave them the opportunity to approach existing issues in a different way:

"*Enabling those community pastors to think differently and think, again, about some of the dilemmas that they're facing with some of their congregation.*" (SM1)

Stronger relationships

Working together towards a common goal, meant that service providers came closer to community leaders and members and built positive relationships which facilitated the process:

"*The relationships became stronger because they got to know each other.*" (SM2)

"*So looking now to see, when you say, what is the value of co-production or the value of bringing communities with public sector professionals together, I think it's probably the only sort of bit of light you can see where it's going to work, to bring people together.*" (WCEN2)

IAPT provided the context for better communication channels and brought people 'round the table' where all sides could talk to each other more:

"*So to have IAPT as a way whereby you come round the table and discuss difficult and interesting things regularly."* (WCEN 2)

"*I think as a model, you know, it works well if people, if it is known as a general exchange between the participants. It's really important because it's about trust building as well.*" (PWP 1)

Mutual gains and feelings of trust were also helpful in strengthening collaborative working between the various stakeholders and promoted a new way of 'negotiated' service through which everyone was a winner:

"*It's a real, you know, a win/win, there's a real, the Trust gets something from this but the community does as well.*" (SM1)

"*I think co-production does engage people and enrol people, you know, it allows the trust to sort of, the positive tentacles to reach out into the community.*" (SM2)

"*The service is negotiated. So it's not just, oh you provide a room in a mosque or whatever and you parachute in, but that what's going to go on in that room and how do we make sure that what goes on in that room it says, because things change, to make it as relevant as possible, so that all the people that we want to make use of the service can do. So that's a big strength.*" (WCEN 2)

2.3.4. Challenges of Co-production

When asked about the sustainability of the co-production process, most participants acknowledged that this was a fairly fragile stage for this initiative and a number of challenges needed to be met in order to ensure continuity and success of the co-production approach. These challenges were mostly linked with organisational issues such as financial commitment from service providers and development of capacity of providers and communities but they were also related to individual attitudes of professionals and of community leaders and their members.

Reluctance to engage fully and lack of commitment

Both community leaders and practitioners noted that there was reluctance on behalf of the services to engage full with the co-production process:

"*I feel that firstly the commissioners, those at that strategic level, need to take it seriously.*" (COL2)

"*I think that might be a way around it, but the person who will do that also would need the support of the wider system and I'm not sure how much of that is around.*" (PWP1)

This reluctance was mostly due to financial reasons and service targets/priorities:

"*Not all senior managers in the Trust have signed up to this – we need more 'buy-in' from them.*" (CDW1)

"*I think it's a challenge, given the current and the future financial circumstances in the wider context, how to keep that as a local priority, even though it might not be a national priority.*" (PWP1)

However, this reluctance was also due to the rigidity and inflexibility of the existing referral and treatment system of IAPT services as noted below:

"*I think one of the biggest problems with IAPT is that what a lot of people actually want is drop in advice. They actually want to come in and be able to see somebody straight away. I think part of the problem, which the IAPT service had, is that you've got to go through a process of triage. And I understand all the reasons why triage has to happen, but some of the things that we've learnt is that a lot of people who need help and support, are not going to do that. They're not going to pick up the phone and speak to somebody over the phone who they don't know. And then talk to somebody who they don't know about their problems, and then be booked into an appointment three weeks down the road. That's just a mechanism that's not going to work ... what they want is somebody to come in and speak to them face to face and offer the advice face to face.*" (WCEN1)

Community organisation leaders put emphasis to the need for continued support and commitment from services in order for co-production to deliver positive outcomes:

"*We need the NHS to continue to support it because that targeted, skilled aspect is needed.*" (COL4)

"*There needs to be that level of commitment there, up there.*" (COL2)

Nonetheless it is not only service providers who showed reluctance to engage with the co-production process; community leaders and their members were also difficult to be involved:

"*Find more ways to engage, not just the leaders of the various communities, but actually the people in these communities.*" (PWP1)

"*I think what's happened over a fifty or sixty year period, is we have eroded people's abilities to cooperate and collaborate and to engage, and agencies, essentially I think through the whole kind of monetarist takeover of government, has become remote from communities. So communities now, people living on the street, they've lost their abilities to connect and communicate and collaborate.*" (WCEN1)

Limited capacity of community organisations

Even if they were experienced in providing support to their communities, community organisation leaders talked about the limited capacity to be co-providers and their need to build on existing skills and experience in order to be more able to deal with the demands of such approach:

"*So we asked Y* [from WCEN] *to help us out and he saw the depth of the work that's needed in such, so if we are to say, oh we can be co-providers, we need to be at that level too. So he needs to be capacity building. Even though we are one of the lead projects maybe, we ourselves still need that help. So what chance do other small projects have?*" (COL2)

"*And what communities have, is very little resources, very little understanding of how power operates, and fragmented, disengaged and marginalised.*" (WCEN1)

Community leaders viewed the NHS as a critical mechanism to support them in dealing with the co-production demands and they expected services to offer this support readily to them:

"*Community projects like us need to have the capacity to deal with it and also need input in capacity building.*" (COL2)

"*The essential need is the support of the NHS because we don't have the skills as a resource to be able to do that.*" (COL4)

Limited skills of professionals

From their point of view, service providers recognised that staff had limited skills to cope with co-production demands too so there was need to develop their skills in better interaction and relationships with communities:

> "*Explaining to therapists how to interact with community groups – needed better preparation for therapists and therapists will have to build their own relationships with co-provider sites.*" (CDW1)

> "*Developing the skills of staff in building relationships, real listening, responsiveness and 'being real'*." (SM2)

Management of expectations

Service providers also referred to the management of expectations as an important challenge to be met; in particular, they mentioned that service providers needed to be clearer to their co-providers, the community organisations, about what they were able to offer and the constraints within which they operate so they wouldn't 'raise hopes' or disappoint community partners when they could not deliver certain expected outcomes:

> "*Being professional, i.e., delivering what we say we were going to, managing expectations, staff have a passion to deliver, they really want to achieve and to make a difference, but are not always managing their expectations.*" (SM2)

> "*Getting the co-provider sites to understand the constraints that we work with – everyone who comes to the table has to know what we work with, what is possible and what is not. It is about managing expectations. We need to think of ways in which the difference or change can be made more tangible for co-providers.*" (CDW1)

Conflicting agendas and issues of power

A major block in full engagement with the co-production process was the perception that different stakeholders had different priorities which would stop them from implementing this approach. The issue of conflicting agendas was noted for both service providers and community organisations:

"*There are different demands from different groups and it is difficult to come to a common understanding or agreement.*" (SM2)

"*Sometimes there are multiple organisations and I think that's important because you cannot, you can say all this, you know, local public service, for example, and the BME community but the different communities need to, you know, they have their own priorities.*" (PWP1)

"*We need to think of ways in which the difference or change can be made more tangible for co-providers. The NHS wants numbers; the co-providers want to know what is making an impact. How do we know who we are reaching?*" (CDW1)

Part of this challenge was the dilemmas professionals were faced with when asked to change their ways of practice and 'release' power to the communities by providing services in a place that is not 'clinical' and being asked to be more involved with the people they provided services to:

"*What professionals bring to the work and some of the skills that professionals have, perhaps in some cases spent many years acquiring. ...concepts such as professional distance is important ....those sort of professional attributes are important to keep in mind as well. I'm not always sure that co-production is engaged with some of those professional dilemmas that many of the staff in the Trust probably tussle with.*" (SM1)

Professional power, which is about skills that are helpful in dealing with mental health problems, can also be a potential barrier for professionals in engaging successfully with co-production:

"*It can be both a strength, because we bring skills to those interventions with people, you know, we can contribute our professional skills to the issues that are brought. But it also brings a dynamic about power I think, it brings a dynamic about power. And I think that, in some ways, can conflict a little bit with co-production, which seeks to be enabling and facilitating.*" (SM1)

"*It is a slow process and the Trust has to release the power to let community groups participate and be active.*" (CDW1)

3. REFLECTIONS

Findings from this evaluation project suggest that co-production networks are helping to build capacity in communities in a more meaningful way – increasing awareness and understanding of community issues, bridging social divides and encouraging a willingness to challenge authority of public agencies. Co-production of services also demonstrates that there are enormous assets among people in communities, both in terms of experiential knowledge and professional expertise. Engaging these skills in a reciprocal way is a way to recognise and develop them further.

In the field of mental health services, this approach can be very beneficial in tackling stigma and discrimination as well as overcoming the barriers BME communities face in terms of access and culturally appropriate service provision.

The Wandsworth model put forward by WCEN, although not thoroughly evaluated, is a useful framework to reflect upon in order to understand the specifics of how IAPT services were delivered in Wandsworth. For example, we discussed in our findings that there were a number of processes/methods through which relationships between the partners of co-production were established and common targets were set such as more flexible referrals and more accessible therapies to BME communities. There was also a principle/key proposition which underlined these partnerships – the acceptance by service providers that community organisation leaders would have better understanding of their members' needs and expectations - which meant that community organisations were in a better position to approach their members and therapies delivered in community locations were more attractive to people in these communities. The practice of collaborative work was developed during this process and it had its 'good' and 'bad' days as all interviewees indicated; a result of power relations between partners and resistance to change. Finally, the challenges identified by our interviewees were both a stumbling block for the future

of this innovative approach and a natural part of a groundbreaking way of delivering mental health services.

It is clear that this approach can only become sustainable if all involved partners are willing to engage fully in the process, something that most of our interviewees found as a significant challenge. They indicated that there was need for a *readiness* of communities and statutory services to be able deliver such a model and embrace this programme from a structural, operational, and community perspective. Readiness is an issue more recently recognised as important for prevention and was emphasised by think tanks and activist organisations that call for a proactive attitude to '*not just talking about change - building the infrastructure to make it happen*' and become agents of change (Robinson, 2011).

If we consider our initial evaluation questions, the association of public agencies and community groups - if not only tokenistic - can create a fruitful environment for overcoming the historical barriers of oppressive mental health services and the institutional racism of service commissioners and providers (McKenzie and Bhui, 2007).

The symbolic gesture of 'sitting around the table' and negotiating services for communities is as powerful as its intentions are, according to our interviewees, and it can lead to opportunities of co-production. In terms of the values that underpin the Wandsworth model of service provision, it was clear from our analysis that development of social capital was crucial for both community organisations and public agencies. Mutual understanding and shared norms such as self-determination and psychological well-being were also emphasised by partners as important ingredients of their relationships. Effective utilisation of existing resources is paramount not only for service providers but also for community organisation leaders.

The new learning that is taking place as a result of this process is shared through frequent meetings and open dialogue between the co-production partners but also through opportunities for change of practice for all. Service providers learn to be more receptive of experiential knowledge made available to them by community

leaders and adjust their practice accordingly while community organisations learn to appreciate the help of public agencies in developing their capacity and skills as well as in promoting better mental health in their communities.

There are a number of benefits for service users and carers, community organisations and service commissioners and providers. Our evaluation evidence suggests that significant positive outcomes in terms of wellbeing and community cultural competence were achieved as a result of this innovative approach:

- **at the intrapersonal level**, all co-production partners referred to the powerful experience of thinking differently about mental health services; being conscious of different cultural groups; feeling empowered and assuming new roles and ways of practice; building social capital and new skills.
- **at the interpersonal level**, a number of our interviewees acted as instigators, mediators and facilitators of change, e.g. WCEN acting as a bridge between communities and service providers; community leaders supporting their members to access mental health services; practitioners facilitating workshops to educate communities about mental health and illness; service providers introducing more flexible referral and access systems.
- **at the collective level**, agreements were made between community organisations and mental health service commissioners and providers to deliver more accessible and culturally appropriate services; these agreements meant that actors of different power were able to interact directly and learn about each other's needs and priorities. The symbolic character of the community location of IAPT services was also an important message for the promotion of preventive mental health practices.

Overall, co-production appears to be very rewarding for both public agencies and communities if supported and implemented with a view to empower people instead of making false economies for the welfare services. The ultimate goal should be that service users become partners in managing their own health however this is a major shift that requires a lot of experience and commitment in the co-production of services and, perhaps, it can only be possible when systemic barriers at community, public agency and state levels are brought down. Nonetheless, the Wandsworth

model of co-production appears to be a promising approach and should be further supported to achieve its full potential.

4. RECOMMENDATIONS

As a way forward, we would propose the following recommendations: We propose that there should be:

- A consistent way of collecting data about the use of IAPT co-produced services that should include demographic information, referral information, length of contact, type of services offered and dropout rates. It would be also important to have all this information by gender, age and ethnic group in order to have a better understanding of the diverse needs of the communities they serve.
- Mechanisms of continuing monitoring and evaluation of the effectiveness of the co-production process by collaboratively identifying meaningful outputs for both service and community co-providers. All partners should be involved in collecting and reflecting on evidence of this joint effort.
- Greater clarity, better and wider information to all co-production partners about what can be achieved through this initiative from the beginning to set common goals for all partners.
- Mechanisms and opportunities for transactional ways of knowledge and information exchange between co-production partners; for example, practitioners holding mental health awareness days for all community members and community organisations offering cultural-specific training for practitioners.
- Mechanisms to involve current service users and carers in co-production and evaluation of co-production to make their involvement more prominent in the various stages of negotiating co-produced services.
- Strategies to maintain the existing fertile terrain that has enabled networks to develop ‘relationships in action’ by developing support for existing networks, but also to provide mentoring programme to enable other networks to become fully operational in delivering new services.

- Strategies to extend transfer of this model to other public services in relation to issues that affect large numbers of people during their lives, such as chronic illnesses e.g. diabetes and cardiovascular diseases.

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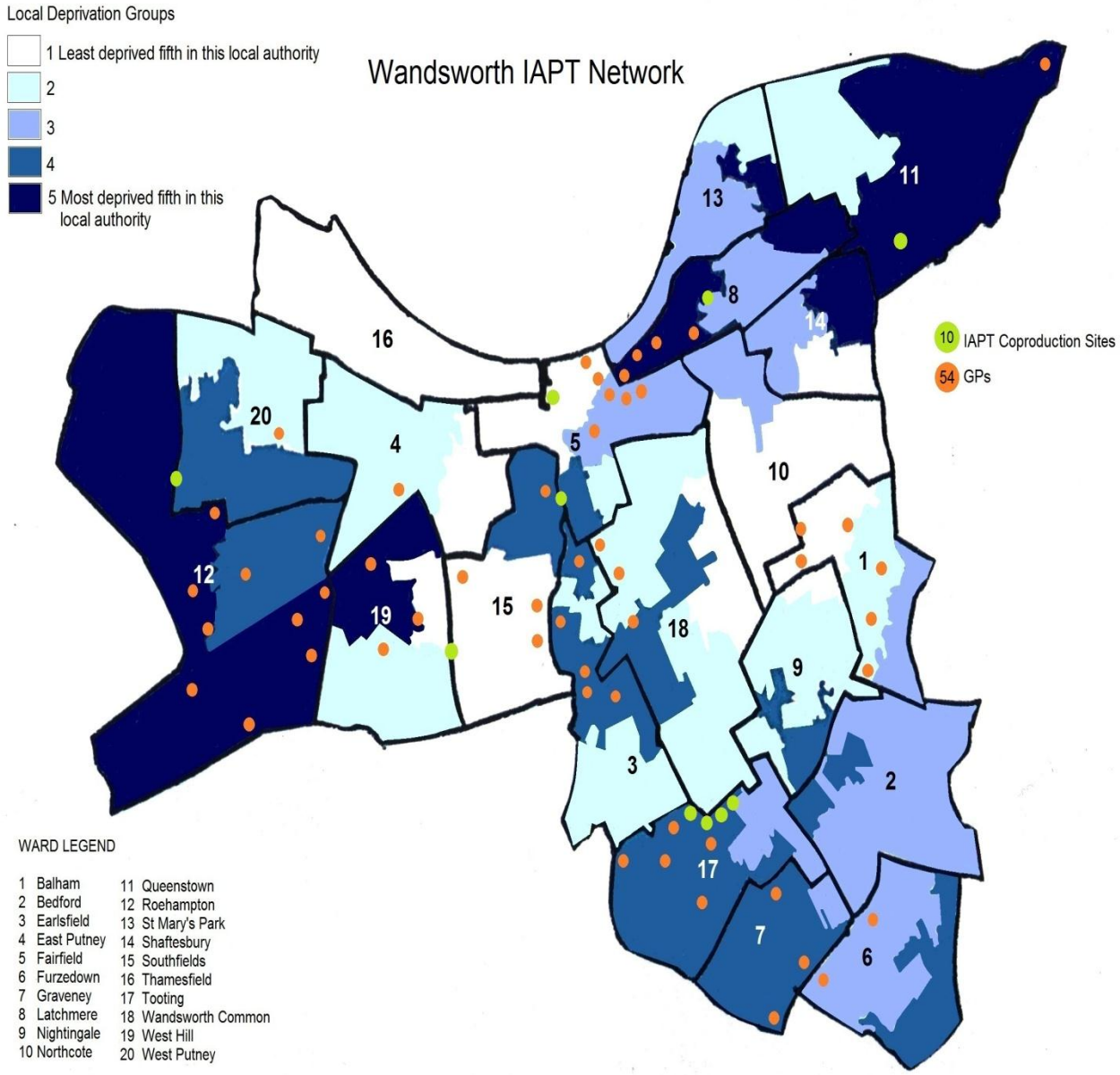
5. APPENDIX A

Map of IAPT Community Sites



6. APPENDIX B

WCEN Brief History (From WCEN Website and 2011 Annual Report)

The Community Empowerment Network in Wandsworth was originally established in 2001 as part of the Boroughs Neighbourhood Renewal (BNR) Programme. Wandsworth was one of the 20 London Boroughs to receive targeted Government funding to help reduce the poverty gaps between the very richest parts of a Borough and the poorest. The BNR Programme came to end in Wandsworth in 2006 and a few years later across the whole country. However, the Wandsworth Community Empowerment Network (WCEN), being one of the very few that was established as an independent charity, has continued its journey of empowering and enabling local people to work with and alongside Public Agencies. In 2008, WCEN began working closely with a number of statutory agencies such as the Wandsworth Primary Care Trust, South West London and St George's Mental Health Trust, and Wandsworth Police as well as community organisations such as Elays (working with young people) and S.T.O.R.M. (working with single mothers) and faith organisations on a number of joint projects. To achieve this, they run – and continue to do so - a series conference and workshops in the borough, across a range of communities and interests, in order to facilitate dialogue between the various statutory and community stakeholders.

CURRENT PROJECTS:

- BME Carers Network: brings together black and minority ethnic carers of people with health and social care needs. It is a user led group that aims to build empowerment and enablement amongst "service users" to influence improved service delivery.
- Provider Site Network: it brings together community groups currently Co Producing the IAPT program and to think through the wider potential of public service delivery in community sites.
- Youth Independent Advisory Group: it works alongside Wandsworth Police and youth led groups MASS FC and Elays Somali Network to influence better police-community understanding and relationships.
- BME Mental Health Forum: It brings together local voluntary and community sector organisations and local people with statutory agencies responsible for mental health services, to build relationships and work through better design and delivery of services.
- Pastors and Family Therapy Network: This Network brings together Senior Church Leaders from local Pentecostal and minority Christian faith communities with the Family Therapy Service of the Mental Heath Trust to share knowledge and skills around systemic family therapy and local communities.

- Merton BME Health Consortium: This is a new network being led locally by Fanon Resource Centre Merton. Building on the learning from the Wandsworth Provider Site Network, they are seeking to share and adapt what we know to enable and empower local groups to accelerate their capacity and processes towards new ways of working.

WCEN's Emerging Network

Churches	**Community Groups**
St Mary & St John's Church Holy Trinity Church Roehampton Seventh Day Adventist Church Yahweh Christian Fellowship St Josephs Catholic Church All Saints Church Tooting Balham Baptist Church Lynwood Christian Fellowship All Saints Church Battersea Park New Testament Assembly Life Tabernacle Church St Anselm's RC Church	Association of Somali Women and Children S.T.O.R.M. Mushkil Aasaan Solace Community Care Limited Tooting Neighbourhood Centre Mass FC Elays Network Fanon Katherine Low Settlement Older Peoples Network DRCA Business Centre
Temples	**Mosques**
Sikh Khalsa Centre Shree Ghanapathy Temple Hindu Society	Balham Mosque Battersea Islamic Cultural & Educational Centre Tooting Islamic Centre Sunni Muslim Association Gatton Road Mosque
Public Agencies	**Learning Institutions**
LB Wandsworth Adult social services NHS Wandsworth South West London and St Georges Mental Health Trust NHS South West London Wandsworth Police Wandsworth Council	Goldsmiths London Kingston University Open University St Georges, University of London University College London

7. APPENDIX C

INTERVIEW GUIDE

1. What was/is your involvement in the provision of IAPT services in the Wandsworth area?
    - Probe for detail re role, interactions with other key players and specific stories
    - Probe for specific experiences with BME/other socially excluded groups
    - Probe how this opportunity came about
    - Probe about their views on what is the value of such association between public agencies and community groups

2. What is your view of the initiative of co-producing IAPT services in Wandsworth?
    - Probe for strengths and weaknesses of the initiative
    - Probe for specific examples of strengths and weaknesses
    - Probe about what they have learned so far
    - Probe about their views on sustainability

3. What are the benefits of this co-production process for service users, communities and service providers?
    - Probe for discussion of benefits for each group separately

4. What recommendations would you make for improving this initiative?
    - Probe for suggestions specific to BME/socially excluded groups

5. Is there anything else I haven't asked you about which you think it is important for us to know in relation to this new initiative?