



ADVOCACY BRIEF

Co-Design and Co-Production

Co-Design:

Identifying and creating an entirely new plan, initiative or service, that is successful, sustainable and cost-effective, and reflects the needs, expectations and requirements of all those who participated in, and will be affected by the plan.

Co-Production:

Implementing, delivering and evaluating supports, systems and services, where consumers, carers and professionals work in an equal and reciprocal relationship, with shared power and responsibilities, to achieve positive change and improved outcomesⁱ.

Background

‘Consumers and carers have a right to participate and have a direct and active role in all processes that affect their lives, and they are directly impacted by the quality and effectiveness of mental health care’ⁱⁱ. Central to co-design and/or co-production, is the end users of services (consumers and carers), must be considered the key stakeholders in mental health, and they are hidden resources, not drains on the systemⁱⁱⁱ.

The terms, definitions and principles of co-design and/or co-production are at risk of becoming co-opted, absorbed and diluted so they become ‘characteristic of the institutions and becoming part of institutionally defined procedure’^{iv}.

Engagement activities undertaken as co-design and/or co-production, without any actual change in the policies, activities or processes of engagement, ‘are not being run in the spirit of (co-design and/or) co-production. This is merely tokenism’^v. It is only when everyone involved, and especially consumers and carers, agree the activity labelled as co-design and/or co-production - that it is.

It is only co-production and/or co-design if consumers and carers agree that it is.

Discussion

‘There has been a slow but steady shift towards the recognition that healthcare providers, healthcare organisations, consumers and carers are all partners in the healthcare system’^{vi}. Originally coined by Elinor Ostrom in the 1970s, and further developed by Edgar Cahn in 2001,



there is growing literature and evidence of the benefits of co-design and/or co-production practices in mental health reform. There are, however, varying definitions, uses of the terms, and awareness of what they mean, where it came from, and how it works. 'Looking beyond surface change, co-design identifies some of the partnership and collaborative practices that have the potential to transform the way in which mental health services are delivered'^{vii}.

Understanding the practices can be confusing, without understanding what they are not. It takes commitment, time and resources to undertake co-design and/or co-production; they are not voluntary or free. If consumers and carers are present, yet their views are not reflected and included in any outcomes, when pre-determined agendas or solutions are provided and details are merely asked to be confirmed, and when decisions are made or overturned without all participants' agreement, and basic principles are not agreed, assured, embedded and mandated in policy and practice, they cannot be defined as co-design and/or co-production.

Based within a human rights framework, and using a strengths-based approach, the practices demand that consumers and carers are valued for their unique assets, expertise and knowledge as having equal power and influence to that of professionals. Consumers and carers 'are not merely repositories of need or recipients of services, but are the very resource that can turn public services around'^{viii}. 'However, this will be challenging in a mental health system that retains significant traces of the history of the control, detainment, isolation, segregation, pathologisation and medicalisation of people with mental health problems'. Exploring myths and stereotypes of attitudes, culture and practices towards consumers and carers, and putting an end to the 'us and them mentality' can lead to a truly transformative approach to reform.

Principles are the basic 'rules' that need to be applied for co-design and/or co-production to be successful. Consumers and carers expect the following to apply:

Equity: Facilitating, rather than directing, open and clear communication. No withholding of, or privileged information; Providing sufficient time and resources to facilitate an open individual and collective learning and capacity-building environment requires giving everyone what they need to be successful, and to share their unique time, talents and strengths with each other.

Equality: Any real or perceived power imbalances are identified and countered, and all planning, preparing and deciding on all details is done with collective and equal responsibilities, authority and decision-making, with the outcomes reflecting the contributions of all those involved. Incentives, remuneration and numbers of consumers, carers and professionals are evenly distributed.

Diversity: Creatively and flexibly providing opportunities for time, people and places, with a genuine commitment to ensuring the views of those not always, or under, represented are included and taken into account; and being fully and openly participatory, requires a conscious and conscientious effort that will optimise results.

Purposeful: The activities and practices must effect real change, with meaningful outcomes for consumers and carers. For all those involved, shaping and defining the agenda, principles, processes, direction and goals, needs to be deliberate and collective. Results achieved, and the co-design and/ or co-production activity itself, is measured, evaluated, documented and includes the experiences of those involved.



Recommendations

- It is only co-production and/or co-design if consumers and carers agree that it is.
- Genuine commitment and acceptance of co-design and/or co-production remains true to the principles of equity, equality, diversity and purposeful. Those principles are agreed, assured, embedded and mandated in policy and practice.
- Genuine commitment to co-production and/or co-design is properly resourced, embedded from the outset; effects real change; and can successfully measure meaningful outcomes for consumers and carers.
- Reform systems and processes must acknowledge and respect the contributions, experience, unique expertise, skills and knowledge of consumers and carers. Any outcomes must represent equally the contributions of all those involved.

Contributing authors:

Lorraine Powell, Kristine Havron, Lyn English, Patrick Hardwick and Norm Wotherspoon.
Please contact NMHCCF Secretariat.

References

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Prepared by the National Mental Health Consumer & Carer Forum
A combined national voice for mental health consumers and carers
T 02 6285 3100 | E: nmhccf@nmhccf.org.au | W: www.nmhccf.org.au