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Co-production in mental health

A literature review

Commissioned by Mind

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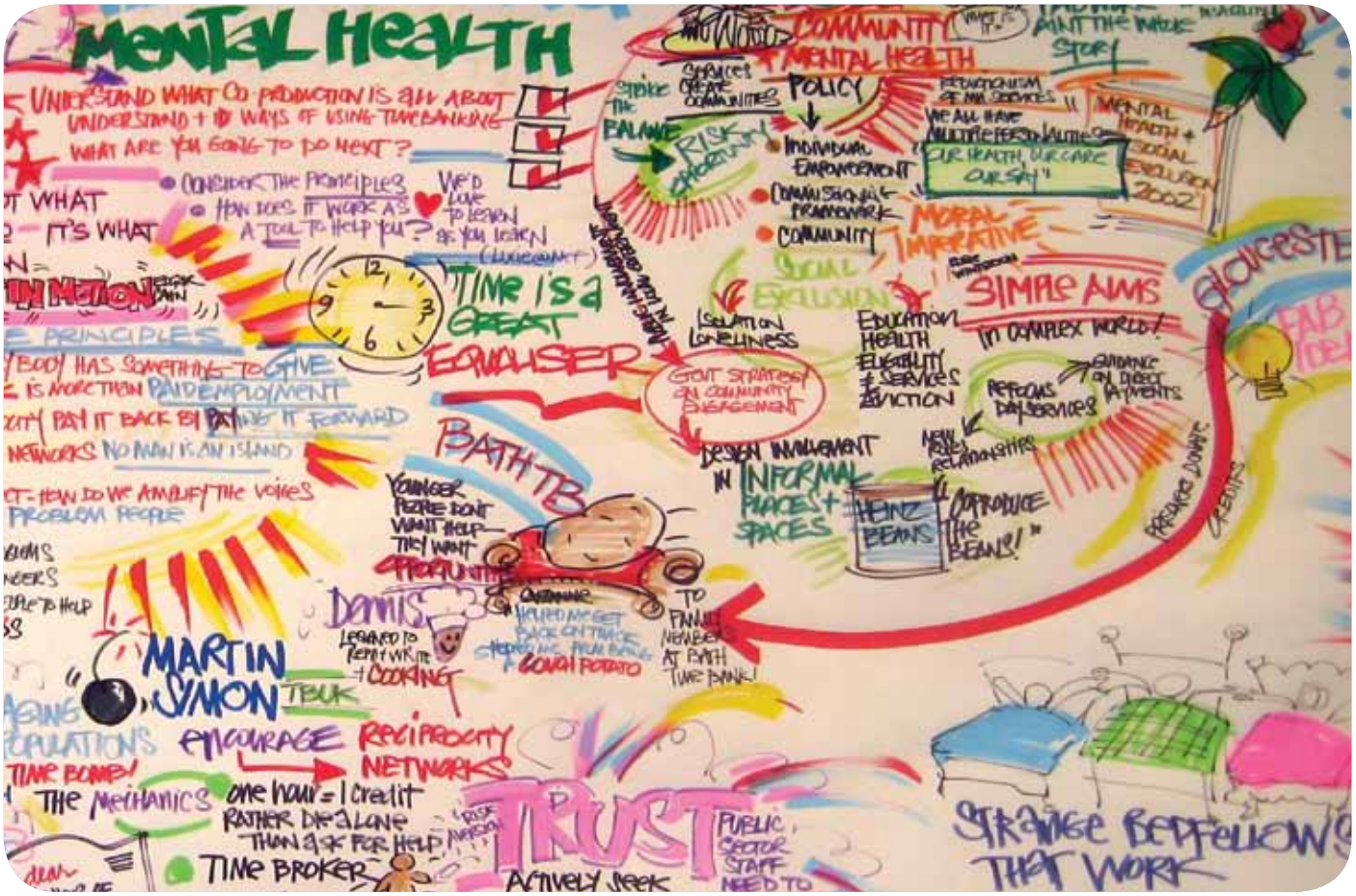
nef (the new economics foundation) is a registered charity founded in 1986 by the leaders of The Other Economic Summit (TOES), which forced issues such as international debt onto the agenda of the G8 summit meetings. It has taken a lead in helping establish new coalitions and organisations such as the Jubilee 2000 debt campaign; the Ethical Trading Initiative; the UK Social Investment Forum; and new ways to measure social and economic well-being.



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Foreword from Mind

We're Mind, the mental health charity. We want everyone experiencing a mental health problem to get the support they need and the respect they deserve.

Our 2012–2016 strategy – Unstoppable Together – recognises that the next few years are a crucial time for mental health. We want to ensure that millions more people are able to access the mental health services that will help them recover and stay well.

Engaging with mental health experts through experience is at the heart of Mind's work. We do this both nationally and through our unique network of local Minds delivering services across England and Wales.

At Mind, we believe that co-production reflects our continuing work to engage meaningfully with the people who use our services. This is reflected in our values as a network and underpins our approach to service delivery. Our ambition is that co-production becomes central to the way the Mind network operates.

In 2013, we commissioned **nef** (the new economics foundation) to carry out a review of existing evidence regarding co-production – examining when, why, and how it has been used in mental health and what impact it has had on people's lives and their recovery.

What next around co-production in mental health?

We will use the evidence and the recommendations from this report to drive our work on co-production in the Mind network and ensure that we are offering the best possible support to those who use our services.

We also hope the findings and the case studies will reinvigorate interest and commitment to co-production in the commissioning, design, delivery, and evaluation of services, in order to truly transform services across all mental health settings. We know that much has been done already in this area but there is much more to do before co-production becomes the norm.

Introduction

In spring 2013, **nef** (the new economics foundation) was commissioned by Mind to review the literature on how co-production is being used in mental health settings. This report sets out the findings of that review, showing what evidence there is of the impact of co-production on mental health support, and which aspects of co-production are being developed in the sector.

The project has been developed within Mind's national programme – the Network Personalisation Programme – to position the network of local Minds as market leaders of high quality, recovery focused, personalised services that individuals want to buy. This programme contributes towards the achievement of Mind's Unstoppable Together strategy (2012–2016) with the ultimate aim of increasing the number of people with mental health problems who are able to access timely and individual support to make their own choices via the Mind network.

The need for this work on co-production within the Network Personalisation Programme emerged in a time of great financial challenge, as a way of exploring additional resources to tap in to for strengthening social care and promoting a better understanding of how to engage with communities in services that promote co-operation, equity, inclusion, and well-being.

We hope the findings are useful for those working in mental health. If you would like to quote this work, please use the reference below:

Slay, J. & Stephens, L. (2013). *Co-production in mental health: A literature review.* London: new economics foundation

Methodology

We used an existing database of co-production literature which is kept by **nef** and updated regularly with new materials to identify the key literature on co-production in mental health. We also conducted a brief internet-based search for any new materials, and sought input from five mental health co-production specialists, who provided additional recommendations for literature. The result was a long list of 24 articles, evaluations, and reports, which we then reviewed. Of these, only 15 were strong enough examples of co-production, or contained an evaluative component. Summaries of the 15 documents can be found in Appendix 1.

We only included literature which had a research or evaluation component about the **impact** of the project. Some interesting case studies were not included as they were about process rather than outcome or impact. Our primary focus was on mental health support and services, but we have also included some social care examples which cover a range of conditions, including mental health, such as Local Area Co-Ordination. We also included some examples of how co-production is being used to support people with personal budgets, but the high volume of literature on personalisation meant we would not complete an in-depth review of how co-production is being applied in this field.

We have excluded literature that relates to co-production in other service settings, but which has positive effects on whole population mental health and mental well-being. We have also excluded the majority of the literature on peer support interventions, due to the volume of literature on the subject, the scope of this project, and the distinctiveness of the peer support approach.

However, we have included a short discussion of peer support as an aspect of co-production in the case studies section.

About co-production

Before setting out the findings of the review, we will briefly outline our understanding of co-production. This will help to clarify the term and to contextualise the analysis of how co-production features in the literature.

Our current working definition has been developed through work with local practitioners and with a national group of 'Critical Friends' with whom we work on researching and promoting co-production. We understand co-production to be:

> *A relationship where professionals and citizens share power to plan and deliver support together, recognising that both partners have vital contributions to make in order to improve quality of life for people and communities.*

There are six principles which are the foundation stones of co-production. Co-production in practice will involve alignment with all of these principles, and they are all underpinned by similar values.

1. **Taking an assets-based approach:** transforming the perception of people, so that they are seen not as passive recipients of services and burdens on the system, but as equal partners in designing and delivering services.

2. **Building on people's existing capabilities:** altering the delivery model of public services from a deficit approach to one that provides opportunities to recognise and grow people's capabilities and actively support them to put these to use at an individual and community level.

3. **Reciprocity and mutuality:** offering people a range of incentives to work in reciprocal relationships with professionals and with each other, where there are mutual responsibilities and expectations.

4. **Peer support networks:** engaging peer and personal networks alongside professionals as the best way of transferring knowledge.

5. **Blurring distinctions:** removing the distinction between professionals and recipients, and between producers and consumers of services, by reconfiguring the way services are developed and delivered.

6. **Facilitating rather than delivering:** enabling public service agencies to become catalysts and facilitators rather than being the main providers themselves.

Most of the strongest examples of co-production have all of these principles embedded in their day to day activities, but some principles may feature more strongly than others.

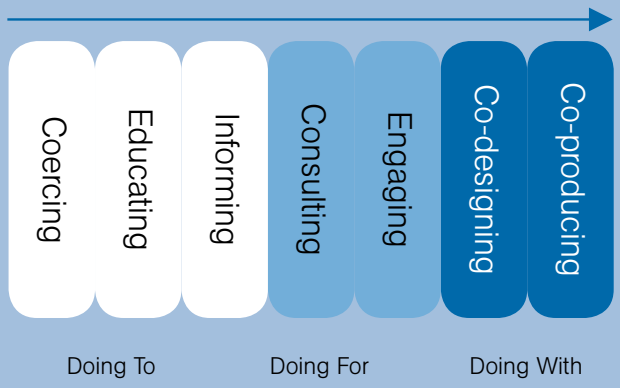
A common question about co-production is how it differs from more traditional approaches to engagement or consultation. We have adapted *Armstein's Ladder of Participation*, which depicts different levels of involvement, to reflect how co-production builds on previous user/professional dynamics. The text below explores how these approaches differ in practice.

Doing to: The first stages of the pathway represent traditional services at their most coercive. Here, services are not so much intended to benefit the recipients, but to educate and cure them so that they conform to idealised norms and standards. Unsurprisingly recipients are not invited to participate in the design or delivery of the service; they are simply supposed to agree that it will do them good and let the service 'happen to them'.

Doing for: As the pathway progresses, it moves away from coercion towards shallow involvement. There is greater participation, but still within clear parameters that are set by professionals. Here, services are often designed by professionals

with the recipient's best interests in mind, but people's involvement in the design and delivery of the services is constrained. Professionals might, for example, inform people that a change will be made to how a service is to be run, or they may even consult or engage them to see what they think about these changes. This, however, is as far as it goes. People are only invited to be heard; they are not given the power to make sure that their ideas or opinions shape decision-making.

Figure 1. An alternative 'Ladder of Participation'



Doing with: The most advanced stages of the pathway represent a much deeper level of service user involvement that shifts power towards people. These require a fundamental change in how service workers and professionals work with service users, recognising that positive outcomes cannot be delivered effectively to or for people. They can best be achieved with people, through equal and reciprocal relationships. Co-designing a service involves sharing decision-making power with people. This means that people's voices must be heard, valued, debated, and then – most importantly – acted upon. Co-production goes one step further by enabling people to play roles in delivering the services that they have designed. In practice this can take many forms, from peer support and mentoring to running everyday activities or making decisions about how the organisation is run. What really matters is that people's assets and capabilities are recognised and nurtured, that people share roles and responsibilities to run the service, and that professionals and services users work together in equal ways, respecting and valuing each other's unique contributions.

Transforming public services through co-production

Needham and Carr's distinction between different levels of co-production is also helpful in understanding how limited – or transformative – the concept can be, depending on how power is structured between people and staff.[1] They describe how, at its most basic, co-production can be used as a 'description' of public services whereby people's action is intrinsic to the outcome, for example, in putting out their rubbish for collection, or taking medication. This conception applies the lens of co-production to existing systems and practice in an attempt to define the relationship between citizen and state, but fails to recognise its 'transformative' potential.[2] An intermediate level of co-production involves a more active recognition of what people using services – and their wider support networks - can offer services. This level might include 'involved, responsible users' who might be involved or have a voice.[3] This level still fails to address power imbalances; it fails to change relationships between people and professionals, and it fails to involve people in day-to-day delivery activities. The third 'transformative' level is what **nef** understands as co-production, which is the transformation of power and control, and the active involvement of citizens in many aspects of designing, commissioning, and delivering services. Needham and Carr observe that the 'the descriptive model of co-production in relation to social care involves the insight that care services cannot be produced without input from the people who use services, even if that is only **compliance** with

an externally-imposed regime'; they warn that in mental health 'the ritual of co-production may very well perpetuate regimes of control/containment for mental health patients that have little efficacy.'[4]

So, our understanding of co-production is informed by

- the presence of the six principles of co-production; and
- how power is balanced between people getting support, and the professionals who deliver it.

Co-production in mental health

This section analyses how the concept of co-production features in the literature, and which aspects and models are most common.

The term co-production is largely absent from the literature. The exceptions tend to be when the studies reviewed were of initiatives closely aligned with or originating from co-production, for example time-banking activities and the Wandsworth Community Empowerment Network Improving Access to Psychological Therapies (IAPT) work, which has explicitly framed its work as co-production . The majority of literature reviewed was more focused on peer support initiatives. To gauge alignment with co-production, we have assessed the prevalence of the six aspects of co-production (outlined on page 3). Table 1 shows the extent to which the six aspects of co-production feature in the case studies.

Table 1 shows that four elements of co-production appear fairly frequently in the literature reviewed. 'Building on people's capabilities' appears in all but two examples, followed by 'developing networks' which is in 12 of the 15 studies. Seeing 'people as assets' features strongly, appearing 11 times. This is unsurprising given the prevalence in the literature of peer support, which commonly takes an asset-based approach recognising the value of lived experience and sharing skills through mentoring and peer networks. The least common aspects of co-production to appear were 'blurring boundaries' (which appeared only 7 times) and shifting professionals from delivering services to being 'catalysts' of change (5 times). This highlights the absence of 'professionals' in many of the examples reviewed, and a lack of focus on the differing dynamic between people and professionals that co-production entails.

Table 1. Prevalence of aspects of co-production in case studies

Element	Assets	Capabilities	Mutuality	Networks	Blurring boundaries	Catalysts
Number of case studies this appears in (15 studies reviewed)	11	13	10	12	7	5

Table 2. Mapping co-production against the design and delivery of services

		Who designs services?		
		Professionals	**People and professionals**	**People using services**
Who delivers services?	**Professionals**	Traditional services		
	People and professionals		C. Co-produced services e.g. Croydon Service User Network, Shared Lives	
	People using services	A. Professionally designed with users employed or volunteering to deliver services, e.g. Expert Patients Programme (EPP)		B. User organised and run peer networks e.g. Clubhouse, Personalisation Forum Group

Table 2 maps how co-production appears in relation to professionally designed and delivered services, and user-created and delivered services.

Below we briefly discuss how the case studies reviewed appear in different areas of the grid above and some of the strengths and weakness of the different areas.

A. Professionally designed services delivered by people who use services

These types of services include the Expert Patients Programme (EPP) and some of the peer employment projects. The format of the programme or service is largely designed by professionals, although the content may be delivered by service users after they have received training to do so. It tends to take place at arm's length from other mainstream services with support from a small group of professionals. They can be viewed as an 'add on' to the existing mental health infrastructure, rather than as integral or potentially transformative. These types of initiatives are often seen to be marginal to the 'real' work done by professionals. As a result they have little impact on the traditional knowledge/power hierarchies within mainstream services. As add on services, they can become financially insecure when funding for services is restricted.

B. Peer networks organised and run by service users

These types of services include the Clubhouse model and the Personalisation Forum Group (PFG). Often they have developed due to a gap in or dissatisfaction with the traditional service model. They exist outside mainstream mental health provision. This often allows them greater freedom and flexibility. They have few, if any, direct relationships with professionals in the system, which limits their capacity to co-produce. Sometimes they are in direct opposition to mainstream services. This can make it very difficult for them to collaborate with professionals who may be able to offer access to valuable professional knowledge or networks. It also makes it harder for them to alter the mainstream model of delivery. These types of organisation can struggle to access mainstream service funding or win commissioning bids and this can make them vulnerable to closure.

C. Co-produced services

The Croydon Service User Network (SUN) has been explicitly co-designed by psychiatrists and service users. SUN members participate in the running of the service, feed back their opinions, represent the groups at the SUN Steering Group and work alongside staff to help in the running of the groups. This ongoing connection between service users and professionals allows for a blurring of roles, and for building greater trust and a sense of shared endeavour. All members are making a valuable contribution, either in running the network, in organising group meetings, or by providing direct support to other members. The involvement of professionals as partners in the group means an active relationship is maintained, creating opportunities to influence professional practice and draw on professional knowledge or networks when needed. It is still the case that SUN hasn't altered mainstream professional practice, but opportunities for collaboration and influence are considerable in comparison with other examples. One aspect of this is that professional allies are funding research and evaluation of the impact of SUN as an intervention. They are in a position to use this information to influence their own professional peers, perhaps more effectively than service users can on their own.

The Wandsworth IAPT programme takes a macro level view of co-production. It is focused on rebalancing power between statutory mental health service providers and the wider community. To achieve this it has developed new relationships between community-based organisations and statutory mental health services. It is focussed on community institutions as assets, enabling community members to access appropriate support in places that have meaning for them. Faith leaders and followers have been trained to provide mental health support in community settings. There are powerful professional allies, with positive independent academic research recently published on the approach. It remains unclear how much professional practice within the larger mental health organisations has altered as a result of this initiative but the community institutions are found to have increased their capacity and networks substantially.

Peer support in mental health

Peer-based support has featured heavily in the evidence reviewed, and constitutes a large body of literature in its own right. It is a growing field, with a range of different approaches – some of which can be more co-produced than others. Rather than focusing on one case study in particular, we have analysed the overarching aspects of co-production, as well as some of the challenges of this approach to indicate how the strength of co-production can vary across examples.

Peer-run programmes can vary considerably in their focus, ownership, and management, and in the extent to which they are integrated into the support offer from statutory services. The following questions are useful in understanding how different examples embed co-production.

Who designed the programme, and who delivers it? For co-production to flourish, professionals and participants need to jointly design and deliver the programme. In some examples professionals have designed interventions in isolation from service users. In these cases it is likely that they will prioritise certain kinds of knowledge or methods of support over others. This then constrains the focus of the programme and the role that service users can play. Similarly, when approaches have been developed purely by service users in complete isolation (or opposition) to professionals, then attempts to co-produce can be constrained. Without professional allies user-led and user-run initiatives can find it harder to access some kinds of information, such as drugs trials or planned changes to local services.

What knowledge or skills are valued and exchanged within the network? Some peer support approaches focus on transferring professional knowledge to service users through training or capacity building. This can explicitly or subconsciously undermine the value given to lived experience or the friendship that can be provided by peers. In contrast, the SUN network values and exchanges lived experience and practical support between members. This gives access to ideas and skills that are different from those that professionals can offer. By including professionals within the SUN network they are able to achieve a positive blend of lived experience and professional knowledge.

Are the benefits of peer support individual or collective? Some peer support work is primarily one-to-one, focusing on individual changes such as increased self-confidence, enhanced self-management, or improved employability. Co-production is about creating collective benefit and mutual gains, such as wider or more diverse networks, as well as individual benefits.

How is power distributed between individuals or across networks? Some reviews of this approach show that formalising peer support by offering payment, training, and titles will inevitably lead to power differences (between peers) – even if these are minimised. It could lead to peers being less than honest (about their own condition) and saying or not saying things through fear of retribution.[5] Despite the introduction of paid peer workers, some studies found that the wider hierarchy of the institution remained unchanged while another layer of the hierarchy was generated. For example 'Peer Support Workers experienced feeling on the one hand part of the team; however, always of lower status than the other professionals.'[6]

What are the expectations around how the networks develop? In some of the reviews networks were described as 'natural', suggesting that they occur without practical or professional intervention. This triggers some concerns. We know that enduring mental health conditions and particularly in times of crisis can be very damaging to people's relationships with families and friends. This will decrease the number of networks available. Offering ideas or practical support to other people requires a certain level of personal confidence, as well as the opportunity to meet and interact. Traditional models of service provision can undermine people's confidence in their own coping skills. Professionals and peer supporters need to be confident about growing their own and other people's networks for support and friendship.

Co-production: analysing the evidence

This section assesses the strength of the evidence and analyses the key themes which emerged in the literature, grouping them in common areas.

What does the literature tell us?

The breadth of the literature on co-production in mental health is relatively small in comparison to many academic studies. That said, considering that co-production is a relatively new concept and still an innovative approach on the margins of public services, The evidence that does exist is promising, and much of it shows strong outcomes emerging for those who get support. There are some very good studies that have explored how the approach (co-production) links to outcomes, and have considered the monetary and non-monetary value of co-production. The literature is primarily qualitative, though some quantitative analysis is included when assessing the economic impact of co-production, predominantly through using social return on investment (SROI) methods.

Though we reviewed a small sample of 15 papers, some common themes emerged across the literature. These relate to outcomes connected to well-being, social connectedness, stigma, inclusion, and personal competencies and skills (e.g. self-esteem, self-confidence). Many of these outcomes align with the core principles of co-production, for example, in developing peer support and social networks, and in focusing on building up people's skills and capabilities.

Another relatively common theme in the literature is the preventative impact of co-production, and a number of studies indicated that their project was preventing more acute needs arising by filling a gap in existing service provision that provides support for people prior to reaching a crisis point. Though the preventative aspect was fairly common, it had not been measured or captured in a consistent way in any of the studies.

Though much of the literature points to the well-being impact of using co-production, with the exception of the Richmond Fellowship and up2us evaluations, none of the projects uses an explicit well-being framework. Likewise, there was very little evidence which used mental well-being or clinical scales to assess different interventions. However, there are strong conceptual links between well-being and co-production which we have explored in a separate section below this analysis and a number of outcomes came up which sit within different domains of well-being.

We also tried to capture some of the evidence on co-production and personalisation from the wider social care field, but have included very few examples as most of the evaluations have so far focused on the impact of the personal budget, rather than on features of co-production. Those examples that do include co-production tend to be case studies, without a research or evaluation component on the impact of the support.

Common themes and outcomes

The key themes which emerge from the literature are:

- Improved social networks and social inclusion.
- Addressing stigma.
- Improved skills and employability.
- Prevention.
- Well-being-related outcomes, including improved mental and physical well-being.

Each of these is explored in more detail below.

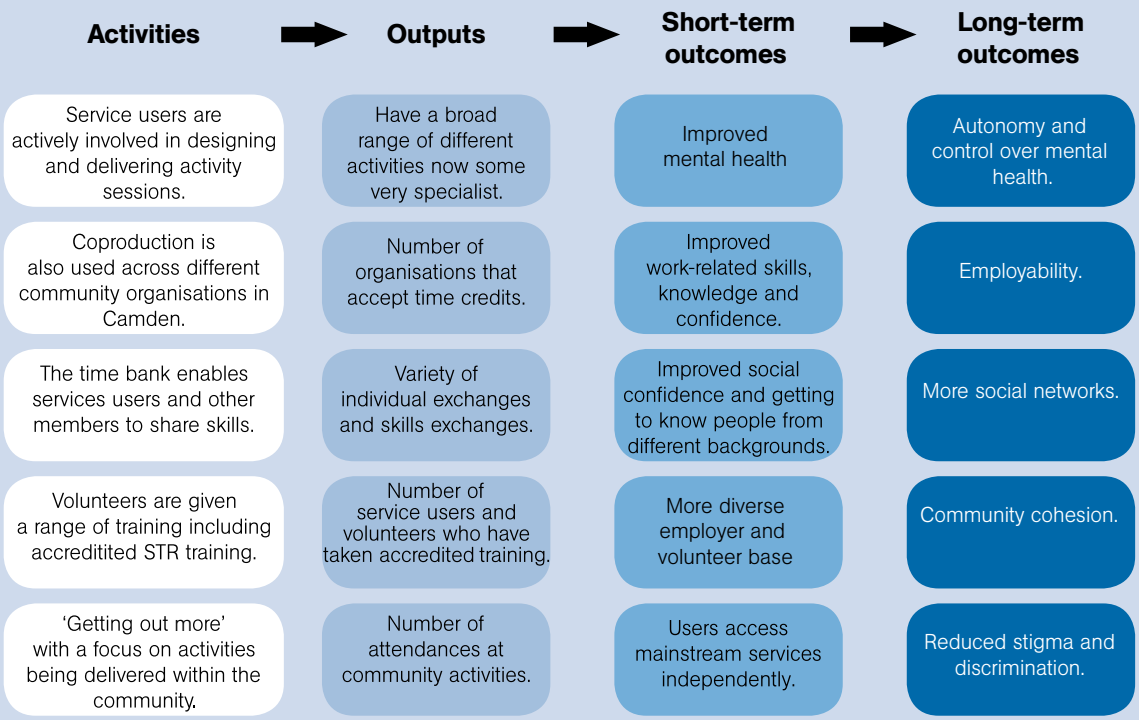
Social networks and social inclusion

The strongest theme to emerge in the literature concerned a cluster of outcomes related to improved social networks and inclusion. This theme was a consistent feature of the literature, and included stronger relationships with peers, family, and friends; a reduced sense of stigma associated with mental health conditions; and a greater sense of belonging to local groups, communities of interests, and networks.

Where evaluations had taken an outcomes-focused approach, common outcomes included improved social networks, feeling valued, greater community cohesion, reduced stigma, and reduced isolation. In some examples, the self-reported indicators for these outcomes were extremely high. For example, the evaluation of the Retain project showed that 90 per cent of participants reported reduced isolation and 28 per cent of participants in the Expert Patients Programme made or sustained new friendships. Some of the approaches based on peer networks of support demonstrated improved support networks (Personalisation Forum Group and Croydon SUN) and that the projects provided formal structures of support, as well as new friends who provided informal support.

The impact map (Figure 2), taken from the Holy Cross Centre Trust evaluation, shows that activities that encourage people to meet others and try new things can lead to individual outcomes: for example, increased confidence in social situations, meeting new people in the medium term, and longer-term community level outcomes, such as greater community cohesion.

Figure 2. Holy Cross Centre Trust Theory of Change Impact Map



Addressing the stigma of mental health services

Another common theme emerging from the literature was reduced stigma for those accessing mental health support and services. This had three aspects: reduced stigma experienced from professional staff in mental health services, less stigma in accessing services, and reduced stigma from the 'community'. The key principles of co-production that address stigma are developing peer and support networks, and eroding boundaries between people and professionals.

In some cases, stigma was reduced because mental health services and support were shifted and physically based outside statutory services, sometimes in people's homes (Shared Lives) or in local institutions, such as faith centres (The Wandsworth Model). The Wandsworth evaluation highlighted the impact the project has had on reducing the stigma associated with mental health services among Black and Minority Ethnic (BME) groups, in particular by working with local community leaders to promote awareness of mental health services, and to base some support within local institutions – such as churches and mosques – that make it more accessible.

In other examples, services actively promoted people's engagement with universal services, such as local leisure centres and colleges, rather than providing training or other opportunities away from public facilities. In doing so, co-production became a method of achieving broader ambitions for social change. The Holy Cross evaluation reported that 'the partnership approach and method of delivering services in the community encourages service users to rely less on their service in the longer term, and also addresses some of the wider inequalities issues, such as stigma and discrimination, that can perpetuate poor mental health and lack of social cohesion.'[7]

The Changing Minds programme evaluation indicated that a peer-led model was particularly effective at challenging stigma from staff towards those with mental health conditions, and that involving experts-by-experience in training and raising awareness among staff and among local groups was successful in challenging stigma and discrimination.

Improved skills and employability

A cluster of outcomes emerged in the literature that included improved skills, knowledge, and engagement with formal learning and training opportunities, and longer-term employment outcomes. The second principle of co-production, 'building on people's capabilities' promotes new activities, skills, and knowledge as one of the main aims of services, and so it is perhaps unsurprising that it emerged as a strong theme in the literature.

Many of the peer-led or experts-by-experience programmes included formal and structured training or self-management programmes, and often led to paid employment. In these cases, employment was often within health services, though some examples did show how people used the experience they had gained to move away from mental-health-related employment.

Other projects used time credits and volunteering schemes to provide people with a variety of opportunities to learn new skills and put these to use in practical scenarios. Some of the projects, including the Mosaic Clubhouse, promote recovery and mental health support in a direct work context, so people are focused on work-related projects as part of their support.

This evidence for employment-related outcomes is particularly strong in the Peer Employment Training Programme in and Changing Minds, both of which include an aspect of formalised training, where participants showed increased engagement in formal learning and sustained employment outcomes. The Expert Patients Programme (EPP) saw a 24 per cent increase in paid employment outcomes.

Prevention

A strong theme throughout the literature was the decreased use of acute mental health services and a reduction in severe and acute mental health needs. There are two aspects to this – at the individual level and the system level. At the individual level, both Shared Lives and Local Area Co-ordination showed how co-producing support developed individuals' skills and capacity, helping them to build up their personal resources and local networks so they have support to stay well and active, and without needing to call on acute mental health services.

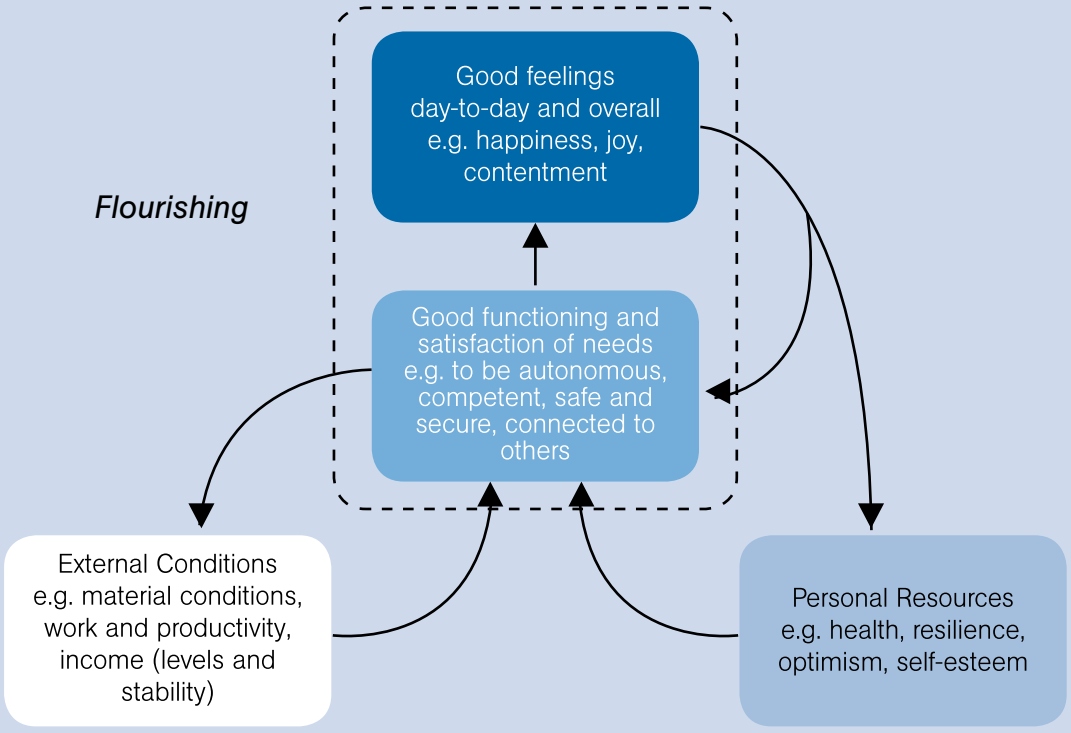
Shared Lives and Local Area Co-ordination also work at the system level, building and facilitating local networks of support that actively try to keep people well, and provide an alternative to statutory services. Peer-based programmes such as the Personalisation Forum Group and Croydon SUN, or the support on offer through time banks such as that at Holy Cross, also do this: they create alternatives to acute services, meaning that people don't have to reach crisis point before they

get support. Evidence from the Croydon SUN programme showed a 30 per cent reduction in use of Accident and Emergency services after six months of members being part of the network, while 16 members of the Personalisation Forum Group said that without the support of the group they would have had an episode in the crisis house or would have been hospitalised over the preceding two years. The Recovery Innovations showed hospitalisations had been reduced by 15 per cent at one centre, while one hospital that was part of the Peer Employment Training approach reported a 56 per cent reduction in re-hospitalisation after one year of implementing the peer support programme.

Co-production and well-being

Well-being was the strongest theme emerging from the literature. Although none of the evaluations except the Retain programme and up2us used an explicit well-being framework, 'improved mental well-being', 'improved physical well-being', and 'improved well-being' came up in a number of the studies. Even more frequently occurring were outcomes related to particular domains and models of well-being. These outcomes tended to fall into two clusters which fit within the 'Personal Resources' and 'Functionings' sections of **nef**'s *dynamic model of well-being* (Figure 3).

Figure 3. The dynamic model of well-being (nef)



The links with these two domains (Personal Resources and Functionings) is very strong, and so we have structured this section of the analysis around a broader explanation of the dynamic model of well-being, followed by an analysis of the relationship between co-production and well-being, illustrated with examples and evidence from the literature review.

The dynamic model of well-being was developed by **nef**'s Centre for Well-being after a major review of the most commonly used approaches to conceptualising well-being. It is unique in that it successfully brings together two of the major theories of well-being – the hedonic and the eudemonic theories – into one framework of subjective well-being.

One of the core components of well-being is how we function (Good Functioning and Satisfaction of Needs – the middle box). This contains three core psychological needs which constitute our ability to function, collectively known as the self-

determination theory (SDT): these are autonomy, competence, and relatedness.[8] There is a lot of evidence showing that these three psychological needs are fundamental to our ability to experience positive life outcomes. The two boxes below – External Conditions and Personal Resources – are major factors in determining our well-being: they are the drivers that can either increase or decrease it. External conditions are all of the factors that exist outside our immediate self, for example, our relationships or employment. Personal resources relate to psychological and emotional characteristics and include factors such as our resilience, confidence, and self-esteem.

The model is dynamic, which means there are feedback loops between the different components that support and reinforce each other. This is illustrated in the following excerpt.

> *Much research suggests that feeling close to, and valued by, other people is a fundamental human need and a defining characteristic of people who demonstrably function well in the world. The need for relatedness to others can be supported through various external conditions of a person's life: at work, through the respect and friendship of colleagues; at home, through the love and support of close family; and so on. Additionally, however, across all of these domains of life, a person who has the psychological resources of self-confidence and optimism may be more likely to make friends and to form relationships. Thus, the extent to which the need for relatedness to others is satisfied is likely to be a function of both external conditions and internal psychological resources. So long as the individual has a sufficient sense of relatedness, this will lead to more positive day-to-day feelings and to a general sense of satisfaction with how life is progressing.*[9]

This indicates briefly how the different components come together and interact to shape someone's well-being. For a more detailed explanation of the model, please see *http://www.neweconomics.org/publications/entry/measuring-our-progress*

Co-production and well-being

A link between the core principles of co-production and some of the components of the dynamic model have emerged through this literature review, which we explore in more depth below. Although none except the Retain and up2us projects used an explicit well-being framework, 'improved mental well-being', 'improved physical well-being', and 'improved well-being' came up in as an outcome in several of the studies.

More commonly cited than the language of well-being were references to outcomes related to particular domains of the well-being model, in particular to outcomes that sit within the 'Personal Resources' and 'Functioning' sections of the dynamic model of well-being. We have broken this down into two sections: (1) Co-production and self-determination theory and (2) Co-production and well-being: personal resources.

1. Co-production and self-determination theory

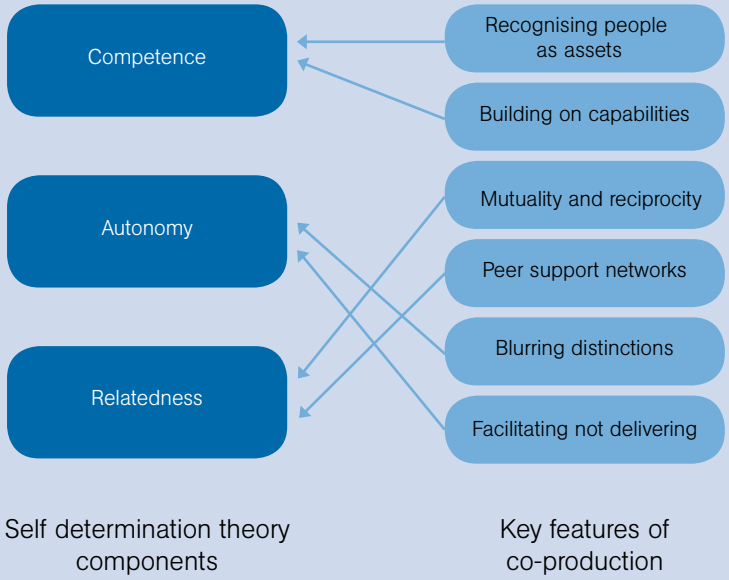
A cluster of outcomes emerged through the literature that relate to the core components of self-determination theory (SDT): competence, autonomy, and relatedness. These were among the main outcomes evidenced from the Holy Cross Centre Trust, Shared Lives, Changing Minds, the Richmond Fellowship, and the Mosaic Club House.

Figure 4 shows diagrammatically how the six core principles of co-production can be mapped across to the three components of SDT.

Autonomy was a particularly strong outcome that emerged from the literature, and may be supported by the focus that co-production places on individual agency, and the change in the professional's role from one who delivers services and therapies, to one who supports and facilitates. The theory of change diagram from the HCCT evaluation (Figure 2, page 10) links the active involvement of people using services in designing and delivering support and activities, to long-term autonomy and control over mental health. Participants in the Arizona Recovery peer employment training programme reported feeling more empowered, and people

being supported by Shared Lives reported feeling more in control, as did those in the Richmond Fellowship programme, and many of the peer-led programmes. Co-production involves a transfer of power towards the person getting support, and so can create more autonomy and control over long-term goals, as well as everyday activities and types of support. In the most powerful examples, such as HCCT and the Mosaic Clubhouse, it encourages people using the service to take a high degree of ownership and responsibility over the running of the service.

Figure 4. SDT components and the principles of co-production[10]



Relatedness is another key component of SDT, and co-production focuses on building social networks and developing relationships among people using services. This is most commonly in the form of peer support, but in some projects it also involves developing new relationships and networks with others in the local area, or with those who have similar interests. This is a strong feature of Shared Lives, HCCT, the Expert Patients Programme, and Local Area Co-ordination. Some of the commonly stated outcomes include increased social networks, greater social cohesion, improved relationships with friends and family, and new friendships. Fostering strong social relationships between people was also an important part of the up2us approach and underpins successful collective purchasing approaches for people with personal budgets.

Competence is the third component of SDT and features in the literature through outcomes related to people learning new skills and competencies. This can be through formalised training programmes, such as the peer training programmes, or through informal opportunities to learn new things, and take part in learning and development opportunities. An explicit feature of many co-produced services is focusing on building up people's skills and capabilities are a core part of 'services'. For example, the Holy Cross Evaluation indicated that '[the time bank] gives people the opportunity to contribute, to learn new skills, and to improve their confidence which has important positive impacts on their mental health'.[11] The Changing Minds project involves formal training courses and one of the core outcomes was increased engagement in formal learning. Other projects, such as the Richmond RETAIN project, focus on building up self-management, communication, and problem-solving skills.

2. Co-production and well-being: personal resources

The second strong theme to emerge in the literature captures a cluster of outcomes that can be described as personal, social, and emotional capabilities, many of which overlap with the 'Personal Resources' section of the dynamic model of well-being. These are sometimes described as inherent characteristics, but can be

supported or eroded depending on the conditions shaping someone's life. They are characteristics such self-esteem, confidence, resilience, improved physical health, skills and knowledge, problem solving, and negotiation and communication skills, and occurred in every example we reviewed. The most common of these were confidence and self-esteem, identified as strong outcomes in the Richmond Fellowship project, Shared Lives, Changing Minds, Local Area Co-ordination Middlesbrough and many of the peer support programmes.

One of the six core principles of co-production is a focus on building up people's skills and capabilities, including these personal resources. The feedback loops within the dynamic model also reinforce and shape these personal resources, so that if someone's functioning improves, and their relatedness or autonomy increases, it can improve their personal resources.

So, we can draw a link between co-production as a means of improving people's functioning as many of the key principles of co-production support and enhance the three pillars of SDT. We can draw a link between co-production and one of the key drivers of well-being: that of personal resources.

The value of co-production

This section explores what value co-production brings to two main stakeholders: the individuals who get support, and the state. In particular, it explores the way new resources – people's time, skills, and expertise – as well as better use of existing local goods and services, can improve the capacity and impact of public services.

The use of co-production brings new resources into the design and delivery of public services, and creates value for those who use public services – and for the state, in ways that are different from more traditional 'top down' services. We can categorise and describe this value in many ways: Figure 5 shows one way of understanding the value that is created by breaking it down into the following three areas:

- **Intrinsic value for individuals:** the value people get through improved outcomes *because of* the approach which is used. For example, building peer support networks as part of a mental health intervention can improve the quality and impact of support.

- **Increased capacity and impact of public services:** the additional capacity created by bringing people's lived experience, expertise, time, skills, and resources into services. This might be through peer-led networks, through working with a broad volunteer base, by using time banks, or through improving the access of marginalised groups to public services by building the capacity of community-based networks – for example faith groups of local schools – to provide support. Working with individuals and groups in this is most easily quantifiable through the number of hours dedicated to creating public outcomes, while the impact of using local networks, experience, and knowledge, while often extremely valuable, is less easily quantified.

- **Monetary value to individuals and the state:** some of the outcomes that people experience can be very easily quantified in monetary terms. For example, employment-related outcomes, or in preventing more acute needs arising, and so reducing the use of crisis services, which was pointed to as a common feature within the literature. All aspects of Figure 5 will create value, but only the last cog represents the monetary value of the activities and inputs.

How has the concept of value emerged in the literature?

Intrinsic value for individuals

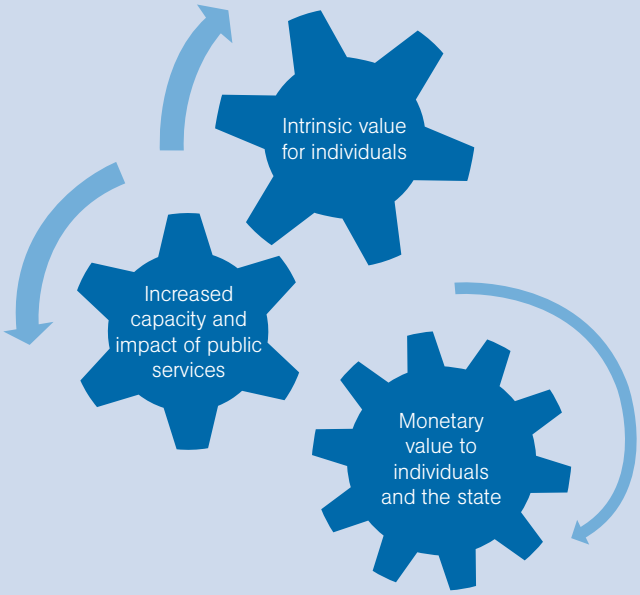
Most of the literature focuses on intrinsic value, which is captured by some of the common themes which emerged in the evidence such as improved well-being, social networks, and connectedness, reduced stigma and increased skills and employability. Many of the individual case studies described powerful stories of personal change through the process of co-production. In particular, the value of developing stronger social networks, and building up an individual's agency, skills, and capabilities had a strong role in achieving change.

Increased capacity and impact of public services

Much of the literature also demonstrated how co-production could increase the capacity of services. This includes:

- **The variety of support and activities services are able to offer.** For example, the Holy Cross Centre Trust can offer a huge range of activities and learning opportunities through its time bank, which it would be unable to deliver if it were just using the time and expertise of its small staff team.

Figure 5. The value of co-production



- **The breadth of expertise and experience.** Much of the literature testified to the value of lived as well as professionally learnt experience, and in particular the way in which peer support can complement professional support, providing practical help away from acute services. The peer-led programmes at Changing Minds, Croydon SUN, and the Personalisation Forum Group all showed the value and impact of combining the time and experience of those with mental health conditions, with the resources of paid professionals.

- **The time available to provide support.** For example, the Mosaic Clubhouse uses 444 hours per week of paid support workers time, which is supplemented by Clubhouse Members providing 849 hours per week, making the service affordable and effective. This is also a common feature of many time banking examples.

- **The value of working in partnership with civil society and the voluntary sector.** Many of the examples showed how working closely with local civic organisations such as faith centres or schools, and better using their influence, networks, and resources, helped to improve mental health outcomes across local populations. The Wandsworth IAPT approach showed how an entirely new layer of mental health expertise can be developed within local faith institutions across a borough, and the impact this has on improving access and addressing inequalities. Much of this value comes from combining public resources with the networks and access of non-state actors – people and institutions – who can reach people who need mental health support, rather than trying to bring them in to services.

Monetary value to individuals and the state

Calculating the benefits of co-production and attributing a monetary value can be done using a range of methods. In the literature we reviewed, it usually involved either attaching a financial proxy to a social outcome, or directly calculating the costs and benefits of co-production.

Some of the value that is created through co-production can be more easily monetised than others. A common method used in the literature we reviewed was SROI, which associates financial proxies with social and environmental outcomes. This can be a very useful way of capturing and communicating value. However, for the purposes of this part of our analysis, we are referring to more directly associated cost savings or cost additions that the state or individuals may experience. Evidence of this within the literature we surveyed was scant, and usually drew

on two calculations of value: the value of unpaid labour brought into the delivery of public outcomes through co-production; and the estimated savings made by preventing more acute needs arising, thereby avoiding costs associated with hospital admissions, A&E visits, or other crisis services.

It is relatively easy to identify the financial value of co-produced support which is based on time banking or peer support initiatives. For example, the Personalisation Forum Group estimated that it had used 13,104 hours of practical support per year, with an approximate value of £250,000. Holy Cross, Changing Minds, and the Croydon SUN are able to make similar approximations.[12]

Calculating the financial value of preventing more acute needs arising is more difficult, though the SUN project does calculate the costs of avoiding A&E attendance, and unplanned hospital attendance, and has measured these statistics for its population over a year-long intervention. However, the savings are often not realised until change happens at a more systemic level, and at a scale where such acute and expensive services can be reduced across local areas or populations.

There is much more literature on how a range of approaches related to co-production creates these different types of value, but which are beyond the scope of this project. These include time banking, asset-based community development, health navigators, befriending services, volunteering, and social prescribing schemes. An evidence review of reciprocal exchange systems (including time banking) was produced by **nef** in 2011 and can be downloaded here.

Appendix 1 provides more detail on the evidence reviewed.

Appendix 1: A summary of the literature

nef, Commissioning for equalities, social return on investment (SROI) analysis
(March 2011) (unpublished)

Summary description of the project

A consortium of mental health services in Camden has a time bank as part of its service, and using this has embedded co-production into the way staff and members work together. Time-bank members run many of the activities at the centre, and their contributions are valued with time credits. The centre has extended the time-bank network to include local organisations such as University College London, the British Museum, charities, colleges, and leisure centres so that members can access these resources using their time credits.

Social outcomes and impact

Short-term outcomes include improved mental health; improved work-related skills, knowledge and confidence; improved social confidence and getting to know people from different backgrounds; users accessing mainstream services independently.

Long-term outcomes include autonomy and control over mental health; employability; more social networks; community cohesion; reduced stigma and discrimination.

Economic or monetary impact

The SROI analysis showed that for every £1 invested in the service by the local authority, over £5.75 in social value is generated.

Most of the value is related to outcomes relating to mental health and employability outcomes, improved social networks, reduced stigma and discrimination, and improved community cohesion. Isolating the value created to the state from the investment of Camden gives a return on investment of more than £3.40 for every £1 invested.

The service relies on service users and time-bank members investing their time and energy, which have been valued in terms of hourly rates at the London Living Wage, to total £137,119.

Shared Lives, *An evaluation of the quality, outcomes and cost effectiveness of Shared Lives services in South East England,*
naaps and IEP (2009)

Summary description of the project

Shared Lives services can provide long-term accommodation and support, short breaks, daytime support, or support for a person in their own home. Shared Lives schemes support people with a range of conditions, including mental ill health. Individuals are supported to live with individuals or families outside institutional settings.

Social outcomes and impact

More than half the focus groups identified the following outcomes for those supported in Shared Lives: living the life the person wants; confidence, skills, and independence; having choices and being in control; having different experiences; having wider social networks; increasing self-esteem; being integrated into the community; physical and emotional well-being; reduced stigma.

Themes include prevention and early intervention, and independence from 'services'.

Economic or monetary impact

Value for money: the variety of schemes make it difficult to compare costs, but the schemes were judged to be good value for money, overall, in providing high quality support for a relatively low price. Better value is also thought to be achieved through the costs avoided through more acute and costly support (the preventative impact).

Cawley and Berzins, *SROI Evaluation of Changing Minds,*
University of East London (June 2011)

Summary description of the project

Changing Minds is a service user leadership programme that recruits and trains local people with experience of a mental health condition, to design and co-deliver mental health awareness courses to challenge stigma and discrimination among staff groups, and in their local communities.

Participants undertake a 9-month part-time training course and, once this is completed, are given the option of being paid to deliver mental health awareness training to staff at South London and Maudsley Mental Health Foundation Trust (SLAM) and other organisations.

It was piloted by SLAM over the last five years. The programme has been expanded to 20 boroughs over the last three years.

Social outcomes and impact

The main outcomes include improved employability and employment; increased social networks; reduced stigma; improved confidence; increased engagement in formal learning.

Specific health-related outcomes include increased mental well-being; better physical health; more physical activity; reduction in medications; reduced visits to health care professionals; sleeping better; weight loss. These effects appear to be sustained over the medium term (2 years) after completing the programme.

Out of more than 100 participants, 77 per cent were involved in challenging stigma and discrimination; 44 per cent are now in full- or part-time work; 27 per cent are accessing further education and 48 per cent are involved in other service user activities like attending meetings, consultations, and volunteering.

Economic or monetary impact

The SROI analysis showed that for every £1 spent in the programme as a whole - £8.78 of social value was created.

Specific economic value for the evaluation cohort of 33 participants suggested that the economic value included:

Increase in earnings, as participants moved into employment: estimated value £139,966

Reduction in benefits received as beneficiaries moved into employment or moved off incapacity benefit: estimated value £19,938

Volunteering hours: estimated value £28,582

Decrease in contact with health professionals: estimated value £22,257

Costs of the programme to SLaM: £74,047

***E. Hatzidimitriadou, M. Mantovani, F. Keating, Evaluation of co-production processes in a community* based mental health project in Wandsworth,**
London: Kingston University/St George's University of London (2012)

Summary description of the project

This project developed a co-produced approach to delivering IAPT inWandsworth, and was evaluated by Kingston and St George's Universities. The 'Wandsworth Model' involves developing partnerships with local faith-based and other community groups, who are engaged in co-producing responsive mental health services. Community leaders are trained in mental health awareness and services are delivered in faith institutions to reduce stigma, and to make them more accessible.

Social outcomes and impact

The main benefits identified for those who access mental health services include: trusting the services; feeling understood and having a sense of belonging; being in a familiar environment; being empowered; tackling the stigma of mental illness among BME communities; and building the capacity of communities to deliver mental health support.

The programme uses the knowledge and relationships held by local faith centres to improve the accessibility of mental health support, in terms of location, stigma, and willingness to seek support. It has also involved working closely with community leaders, increasing the reach and capacity of the service, often using very culturally specific expertise to tailor support to the needs of particular religious or ethnic groups.

Economic or monetary impact

N/A

The Wandsworth approach is also allowing individuals and communities to take 'early action', and so has a preventative impact.

End of Project Report, Retain Regain
www.richmondfellowship.org.uk

Summary description of the project

Retain Regain supports people who are experiencing common mental health problems (stress, anxiety, and depression) to stay in work or regain work at the earliest opportunity. It takes a self-management and capacity building approach, supporting the individual to explore solution-based planning, use mediation, and access professional support.

Social outcomes and impact

Common outcomes experienced by individuals include dealing with difficult issues more effectively; feeling more confident; feeling less isolated; feeling listened to and valued; understanding and managing their own mental health more effectively; communicating their thoughts/feelings and needs more effectively to their employer.

People also benefitted from improved self-management, increased job control, increased self-esteem, and an increased sense of belonging within a community.

Client feedback has been sought via an evaluation questionnaire which showed that:

- 98 per cent reported reduced isolation.
- 87 per cent reported an improved sense of independence.
- 90 per cent reported an increased ability to address problems/ negotiate solutions at work.

In addition, the number of direct beneficiaries who have retained their job (stayed in current role) or changed job (either redeployment or new employer) has consistently remained at over 70 per cent during the project lifetime.

Economic or monetary impact

Peter Fletcher Associates Ltd, *Evaluation of local area co-ordination in Middlesbrough*
(August 2011)

Summary description of the project

Local Area Co-ordination is an approach to supporting people with a wide range of support needs within the community, and has a number of aspects of co-production. A co-ordinator supports people to build up their skills and capabilities, and provides a linking role to both

Social outcomes and impact

The benefits of Local Area Co-ordination include: early intervention – stabilising situations and helping people build up their confidence to deal with issues; working with people at a grassroots level to support those who might otherwise be hidden to statutory services.

Economic or monetary impact

The budget for Local Area Co-ordination for 2010/2011 was £146,186. Of this, staffing accounted for £119,922 i.e. 82 per cent. An hourly cost for the service has been calculated at £33. That would give a cost per case so far of £92. There are no benchmarks

community-based support (including peer support) and statutory services.

Local Area Co-ordination was developed in Western Australia, and has also been taken up in Scotland and parts of England. The Middlesbrough project has an explicit focus on supporting those with mental health needs, and has had a recent evaluation conducted. Mental health needs formed the highest proportion of support needs, and most of these are low level support needs (i.e. they do not have a severe and enduring mental health illness). The vision of Local Area Co-ordination in Middlesborough is 'all people live in welcoming communities that provide friendship, mutual support, equality and opportunities for everyone, including people vulnerable due to age, disability or mental health needs, their families and carers'.

People who used the service all said it made a positive difference to their lives. Local Area Co-ordination was seen as consistent, non-judgemental, based on what people wanted to achieve for themselves, providing practical support, local, accessible, and non-stigmatising

to compare this with but it does seem to be a low figure and a good indication of value for money. The cost-effectiveness would increase significantly if the team were working to full capacity.

Strong evidence of improved outcomes and cost savings have been shown through the Australian evaluations, but this model was specifically developed for those with learning difficulties, and did not cover mental health conditions.

The peer-employment-training (PET) approach of Recovery Innovations in Arizona
http://www.govint.org/good-practice/case-studies/employability-for-people-with-mental-illness/
http://www.centreformentalhealth.org.uk/pdfs/GeneJohnson_recovery_transcript.pdf

Summary description of the project

Recovery Innovations Inc., is an organisation focused on recovery support for adults with serious mental illness and substance use issues. In the late 1990s the organisation began to fundamentally transform the way it provided services to its users. It has placed significant emphasis on peer support approaches, moving it from the fringes to the mainstream of provision.

The Peer Employment Training (PET) programme gives people who have used psychiatric services the opportunity to train as Peer Supporters. It is now providing services in five states in the USA and also in New Zealand. The 70-hour training programme is now used in 16 US states. The programme is being expanded to facilitate access to housing for people with mental health problems.

Social outcomes and impact

Evaluation of the PET has shown high levels of employment in psychiatric services for people completing the programme.[13]

Participants reported feeling more empowered after completing the programme and having higher self-worth.

89 per cent of participants were still working after a year. 247 peers are currently employed in the Arizona programme, which represents 72 per cent of the Recovery Innovations Inc total workforce. 73 per cent of this group are in leadership positions.[14]

Compared to traditional staff, peers were likely to have higher expectations of those they supported and were less likely to 'catastrophise or pathologise' people's situations.[15]

In the first year that peers worked in one hospital, there was a 36 per cent reduction in seclusion and a 48 per cent reduction in restraints.

Economic or monetary impact

Before implementing the programme, one centre had a 25 per cent rate of hospitalisation. Fifteen months after introducing peer support, that figure dropped to below 10 per cent, representing a saving of roughly $10 million.

One hospital reported a 56 per cent reduction in re-hospitalisations after one year of implementing the peer support programme.

Peers worked with people with a high likelihood of being in hospital, in jail or homeless. 95 per cent of the people who enrolled in the programme got a lease in their own name. After two years 77 per cent of the 120 people who enrolled in the programme no longer needed a subsidy for their rent.[16]

Healthy Lives equals healthy communities: the social impact of self management,

EPP CIC (2011) Sourced from the Expert Patients Programme website: http://www.expertpatients.co.uk/publications/healthy-lives-equal-healthy-communities-social-impact-self-management

Summary description of the project

The Expert Patients Programme is a Community Interest Company (EPP CIC). It provides and delivers free courses aimed at helping people who are living with a long-term health condition to manage their condition better on a daily basis. The aim is to give people the confidence to take more responsibility to self-manage their health, while encouraging them to work collaboratively with health and social care professionals.

In 2011, the EPP CIC commissioned an SROI evaluation to identify the social (non-clinical) outcomes which happen as a result of various EPP-related programmes. The evaluation focused on the EPP CIC programme in the Wirral.

Courses are generally made up of six weekly sessions, each of 2 ½ hours. They cover topics including dealing with pain; coping with depression; relaxation techniques; healthy eating; planning for the future; and communicating with family, friends, and professionals.

Social outcomes and impact

The evaluation found that:

- 24 per cent of participants took part in volunteering.
- 16 per cent started patient or community groups.
- 24 per cent gained employment-related outcomes.
- 27 per cent improved their relationships with family.
- 24 per cent improved their relationships with existing friends and 28 per cent made and sustained new friendships.

Economic or monetary impact

The EPP programmes in the Wiral create a total social return of £212,255.

For every £1 spent on EPP programmes in the Wirral, £6.09 of social return is created in addition to the health benefits.

S. Duffy, *Peer power: An evaluation of the Personalisation Forum Group. A user-led organisation (ULO) for people in Doncaster,*

Centre For Welfare Reform (2012)

Summary description of the project

The Personalisation Forum Group (PFG) is a user-led organisation (ULO) with over 60 members, established in Doncaster in 2010. They set up PFG when they 'decided not to be service users'.[17] Their aim is to 'promote wellness through community involvement and investment in our citizens'.[18] They have now created several positive interventions including a system of mutual support called Support Buddies. This is a flexible system that enables members of the group to give and get daily support from each other.

The group has had consistent facilitation by an independent social worker who has not charged

Social outcomes and impact

People report that supporting others makes them feel good about themselves.

16 people say that without the support of the group they would have had an episode in the crisis house or would have been hospitalised over the last two years.

Three members experienced a week's stay in the crisis house. They all reported that their recovery wouldn't have been possible without the support of the group.

Only two members of the group have been detained in hospital over the past two years. One lady reported having yearly periods of

Economic or monetary impact

The scheme has provided 13,104 hours of practical support per year, with an approximate value of £250,000.

Each person provides about six hours of support per week. This equates to 252 hours of support available per week.

Support increases radically when members are in crisis – the maximum has been 500 hours of support provided in one week (which equates to over £10,000).

for this support. Through Support Buddies people exchange 'support credits' for a range of support including attending appointments, social activities, transport, hospital visits, a telephone support network, help with form filling, craft group, budgeting, shopping, planning, and crisis intervention. Ten members of the group are trained and providing peer-to-peer therapy. Two members are trained to facilitate and support others to complete the WRAP process – Wellness and Recovery Action Planning.[19]

detention for the last 19 years. Her last stay was over a year ago and only lasted three weeks which she reports is significantly reduced because of support from her peers (previous stays had been for months).

Two members report that they would not be able to continue with their caring role without the support of the group.

One member now has full-time employment.

The group reports having reduced expenditure in 'medication costs, hospital beds and crisis services, domiciliary care, day services, social work time and support from psychiatric nurses'.[20]

J. Slay, *Budgets and beyond: interim report*, *nef (2012)*

Summary description of the project

This report reviewed the literature on personalisation and co-production across social care; the evidence on mental health specific services was limited.

Social outcomes and impact

Depending on the activity, service, and sector, co-production has been shown to improve well-being; improve social networks; improve employability; improve social inclusion; improve mental and physical health; reduce use of acute services; increase participation in community activities and civic life.

Co-production can be particularly effective at supporting those seen as 'high risk' or as 'vulnerable' to take a more active role in civic life and to address barriers of stigma and social inclusion.

Economic or monetary impact

Economic value was shown in the following ways:

Additional capacity. Co-producing services brings additional capacity to support and sustain public agencies in their efforts. This consists of the time that people bring to supporting the service, the value of their experience and skills, and the increased scope and scale of various activities.

Prevention. Where support is co-produced, it can prevent more acute needs arising as it actively seeks community-based solutions and supports people to build up their capacity, remain independent, and take an active role in community life; the effect is often to reduce their need for services in future.

Cross-sector benefits. Many of the benefits that are a result of co-production accrue to sectors outside those where the service or activity takes place. These cross-sector benefits have a major impact on reducing the demand for services, and on increasing economic contributions to the state in the form of tax revenues, or reduced benefits, if people are supported into work.

Economies of scale. Positive gains can be made by individuals through pooling their resources (whether individual budgets, or otherwise) and collectively accessing support and services.

Croydon SUN (Service User Network), unpublished literature and J. Slay, L. Stephens, and J. Penny, *People Powered Health: Co-production Catalogue*,
nef, Nesta, Innovation Unit (2012)

Summary description of the project

Croydon Service User Network (SUN) is a support network developed for and by people with longstanding behavioural or emotional issues (personality disorders) in Croydon. SUN brings together people who share the same experiences to support one another in formal and informal ways. SUN uses peer support networks to improve people's coping strategies, bringing together groups who have similar problems and who can help each other during times of crisis. This works because within a group crises rarely occur simultaneously so there are always people on hand to help out. Groups are co-run by professionals and support facilitators. Support facilitators are former members of SUN who have a lived experience of personality disorder. They are employees of South West London and St George's Mental Health NHS Trust and are given ongoing support and training within the staff team.

Social outcomes and impact

Members have reported that support from other members can make a big difference during times of crisis. Knowing that there are other people worrying about them in the community can mean a great deal.

The formal and informal nature of the support network means members are able to access help out-of-hours.

SUN members participate in the running of the service, feed back their opinions, represent the group at the SUN Steering Group, and work alongside staff to help in the running of the groups. SUN is also developing voluntary positions for group members wishing to take a more active role in the service.

Economic or monetary impact

Planned hospital visits decreased from 725 to 596.

Unplanned hospital visits decreased from 414 to 286.

Hospital bed day use decreased from 330 to 162 days after six months of members being part of the network.

A&E use decreased by 30 per cent after six months of members being part of the network.

Mosaic Clubhouse, Lambeth
http://www.mosaic-clubhouse.org/
http://www.govint.org/good-practice/case-studies/mosaic-clubhouse-co-producing-improved-mental-health/

Summary description of the project

The objective of Mosaic Clubhouse is to help people who have experienced mental ill health to stay out of hospitals and enable them to return to society. Clubhouse members provide mutual support in their journeys towards recovery; they help members to regain self-confidence, self-belief, and self-esteem by identifying their current strengths, as well as developing new skills; they enable members to move on in their lives and achieve their own personal goals.

The Clubhouse employment programme aims to bring structure to the lives of its members with an 8-hour work day – paralleling typical business hours. Staff and members work side-by-side to carry out the work of Clubhouse – from administration to cooking meals in the kitchen.

Social outcomes and impact

Working in the units allows members to develop job skills, to perform real work that is valued by the Mosaic Clubhouse as a charity and as an organisation.

Provides members with dignity and the feeling of being a valued member of the community. This sense of belonging is powerful in promoting positive mental well-being and integration into the job market.

Support and encouragement from people who have experienced mental ill health ('expert patients') is often more valid and powerful than support from 'professionals'.

Economic or monetary impact

The Clubhouse requires 444 hours per week of paid support workers' time. This is supplemented by Clubhouse members providing 849 hours per week, making the service affordable and effective.

The Clubhouse arranges for members to obtain a transitional employment placement which generally lasts between six and nine months. Members are then replaced with the outgoing Clubhouse member training the incoming member. This means there are no training costs for employers.

Clubhouse guarantees absence coverage to all their transitional employers. This approach is unique to Clubhouse and provides the most supportive and risk-free opportunity for both its members and their employers.

J. Repper and T. Carter, A review of the literature on peer support in mental health services,
Journal of Mental Health, 20(4): 392-411 (August 2011)

Summary description of the project

Although mutual support and self-help groups based on shared experience play a large part in recovery, the employment of peer support workers (PSWs) in mental health services is a recent development.

The literature demonstrates that PSWs can lead to a reduction in admissions among those with whom they work. PSWs have the potential to drive through recovery-focused changes in services.

There are three broad types of peer support:

- Informal (naturally occurring) peer support.
- Peers participating in consumer or peer-run programmes.
- Employment of consumers/service users as providers of services and supports within traditional services.

Paid employment of PSWs within mental health services in the UK has been slower to develop than in the USA and elsewhere, possibly impeded by negative assumptions about the abilities of people with mental health problems to support others.

Social outcomes and impact

PSWs appear more successful than professional staff in promoting hope and belief of recovery; empowerment and increased self-esteem; self-efficacy and self-management of difficulties and social inclusion; engagement and increased social networks.

Employment as a PSW brings benefits for the PSWs themselves in every reported evaluation. The experience of valued work in a supported context, permission to disclose mental health problems – which are positively valued – all add to self-esteem, confidence, and personal recovery. Employment as a PSW also increases chances of further employment and continued recovery.

Admission rates

Randomised controlled trials (RCTs) comparing the employment of PSWs with care as usual or other case management conditions report either improved outcomes or no change (meaning PSWs were all at least as effective as interventions by 'paid professionals').

Wider evidence on admission rates report positive results, suggesting that people engaging in peer support tend to show reduced admission rates and longer community tenure.

Discharge involving peer support significantly reduces readmission rates and increases discharge rates.[21]

Consumers involved in a peer support programme lived in the community longer and had significantly fewer rehospitalisations over a three-year period.[22]

Empowerment

Participation in peer support as both a provider and recipient resulted in increased independence and empowerment.[23]

Economic or monetary impact

Evaluation of an Australian programme providing hospital avoidance and early discharge saved more than 300 bed days in 3 months when peers were employed as supporters for people at this stage of their recovery.[34]

There was found to be a 50 per cent reduction in re-hospitalisations from peer support outpatient programme, compared with the general outpatient population. Only 15 per cent of the outpatients with peer support were rehospitalised in the first year of programme.[35]

Consistent engagement in peer support increased stability in work, education and training.[24]

Participants reported gaining control of their symptoms/problems and becoming more involved in their treatment, thereby moving away from the traditional role of 'mental patient'.[25] Peer support can improve self-esteem and confidence.[26,27]

Social support/functioning
Individuals involved in peer-run services had improved social functioning compared with individuals in traditional mental health services.[28]

People continuously involved in peer support programmes over three years scored significantly higher than comparison groups on a measure of 'community integration'.[29]

Participants who received peer support demonstrated improved social support, enhanced social skills and better social functioning.[30]

Reducing stigma
Participants involved in peer support were less likely to identify stigma as an obstacle for getting work and were more likely to have employment.[31]

Benefits for peer supporters
More than half of PSW respondents (study of 14) indicated that they benefited from the feeling of being appreciated; they felt their confidence and self-esteem increased and this further facilitated their recovery.[32]

Providing peer support is more beneficial than receiving it in terms of self-esteem and empowerment, etc.[33]

M. Pagano, Helper Therapy Principle
Sourced from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2727692/

Summary description of the project

Originating in Akron, Ohio, in 1935, Alcoholics Anonymous's primary purpose is for members to stay sober and to help others to recover from alcoholism. By getting out of self, the alcoholic reduces self-absorption and self-pity each time they shift the focus from self to others by helping. Helping behaviour in Alcoholics Anonymous often means becoming a sponsor to another alcoholic. A sponsor typically has been sober for a year or more. Helping behaviour is not limited to the formal role of sponsorship. Informal helping behaviour occurs earlier in the process of recovery, such as putting out coffee, cleaning up after meetings, or listening to another alcoholic's problems that day.

Social outcomes and impact

The mental health benefits of helping others more than double when the helper helps another with the same chronic disease.[36]

The mental health benefits of helping others include: mood improves, depression and anxiety decrease, self-esteem increases, and purpose in life is enhanced.[37,38,39,40]

The first longitudinal investigation found that alcoholics who helped others during treatment were twice as likely as non-helpers to have maintained sobriety for one year following treatment.[41]

A naturalistic study of adults with comorbid substance use and body dysmorphic disorders (a severe mental illness) found that helpers were twice as likely to achieve sobriety in the absence of a formal treatment intervention.[42]

Economic or monetary impact

N/A

L. Stephens and J. Michaelson, Buying things together. A review of the up2us approach – supporting people to pool budgets to buy the support they want,
nef and HACT (forthcoming, 2013)

Summary description of the project

Up2us was set up to investigate how personalisation could be co-produced in housing care and support. Six pilot areas in the UK aimed to develop and test ways of bringing people together to pool money in order to buy the care and support that they want. Over three years the practical activity of the pilots was diverse and included:

- Building a user formulated community networking web portal that brings together local people, local knowledge and local resources.
- Residents organising shared activites in Extra Care housing and playing a role in commissioning future services.
- Young people with a history of homelessness making purchases to improve their health and well-being.

Social Outcomes and Impact

Up2us attempted to assess the impact of the pilots on well-being, using a combination of quantitative and qualitative methods: a set of 'before' and 'after' questionnaires, and a secondary analysis of in-depth interviews, using a well-being lens.

The questionnaire responses revealed that:

- A big majority of people said they would like to continue their involvement with up2us and would recommend similar activities to other people.
- The most common changes people attributed to being involved in up2us were undertaking more activities and trips, going out more often, meeting new people, and making friends.

Economic or monetary impact

N/A

• Setting up a user-run co-operative with members planning and taking part in activities at weekends and in the evenings. • Jointly buying gym equipment. • Jointly commissioning shared overnight support. • Using participatory budgeting to organise day centre activities.	• After being involved people were more positive about getting the right support to help them live their daily life and being part of a group which supported each other. • In the second questionnaire people gave more positive responses to questions about making choices in their daily life and getting the chance to do things they are good at.	

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Special thanks to: Paola Pierri and Anna Coote

Edited by: Mary Murphy

Designed by: danfarleydesign.co.uk

Cover Image: reway2007

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Registered charity number 1055254

ISBN: 978-1-908506-50-4