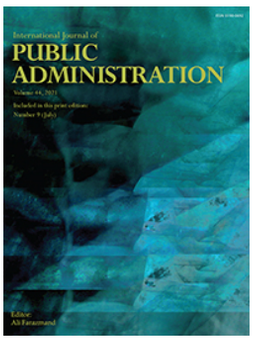

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Time is on our side: operationalising 'phase zero' in coproduction of mental health services for marginalised and underserved populations in London

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ABSTRACT

Coproduction is increasingly positioned as the gold standard for improving health engagement with marginalised groups. Yet little is known about how key factors such as power, position and culture impact success. Our research aims to identify the psychosocial factors and resources that enable successful coproduction between Black, Asian and other Minority communities and statutory agencies within a coproduction network for mental health services in London. Within our multi-site ethnography, 53 individuals completed: participatory learning appraisal (PLA) workshops, focus groups, and semi-structured interviews. Unstructured observations of network activities were also completed. Data were analysed using thematic network analysis.

The findings highlight that coproduction is enabled by symbolic, relational and material resources. Resources are input before coproduction activities begin, within a newly conceptualised 'phase zero'. Unconstrained by typical funding cycles, the phase shifts power, resources and relationships through recognising and addressing power asymmetries and histories of oppression facing marginalised groups. Implications for coproduction are discussed.

KEYWORDS

Coproduction; mental health; Black Asian & minority ethnic communities; power; social capital; London

Introduction

Globally, participatory approaches have emerged as the panacea to overcoming health service challenges (Haldane et al., 2019). An era of person-centred care has fostered a renewed focus on increasing the participation of service-users and marginalised groups in health systems planning and delivery. Coproduction in health, defined by Kickbusch and Gleicher (2012) as a process to achieve shared responsibility for health governance and care, involving governments, sector providers and 'active' citizens, is the latest iteration of patient engagement approaches. Coproduction's appeal lies in its ability to prioritise patient engagement within multi-disciplinary treatment and care (Barello et al., 2014) systematically shifting focus to 'what matters to you' rather than 'what's wrong with you' in treatment spaces (Bovaird & Loeffler, 2012).

This process does not occur in a vacuum. For mental health services in particular, service improvement and patient engagement are embedded within a history of violence(s) (Rose, 2008; Sweeney et al., 2015). For service users from Black and Minority Ethnic backgrounds, this includes historic over-representation of mental health services; increased likelihood of diagnosis of severe mental health disorders (Kirkbride et al., 2008) and being sectioned under the Mental Health Act (2007) (Mental Health Foundation, 2014). Such outcomes are linked to racism in services, alongside higher exposure to socio-structural drivers of poor mental health – including poverty, unemployment, incarceration, and other comorbidities across high-income settings, including Canada (See: King et al., 2009), the United Kingdom (UK) (See: Fernando, 2014, Barnett et al., 2019) and the United States (Wang et al., 2005). In the UK, coproduction approaches are suggested as a potential route to changing such outcomes. However, given the complex realities faced by those marginalised, responses to questions such as 'what matters to you' may include desires for change beyond the perceived remit of health systems. In the absence of more complex responses, service-user engagement emerges as a tokenistic exercise, with groups feeling they have been used to meet statutory aims (Rose & Kalathil, 2019). What is required to make coproduction a process that responds to the voiced needs of historically marginalised groups, and avoids the pitfalls of previous generations of tokenistic participatory engagement?

Our paper responds to this question through an evaluation of a coproduction network in South London anchored to the improvement of mental health outcomes for racially minoritised communities. Our multi-site

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ethnography illuminates the complexities of systems, practices and contexts driving coproduction, which are often overlooked by existing studies, but are identified as critical to our understanding the *how* of coproduction (Palmer et al., 2018).

Background

Despite coproduction's heritage in the well-established field of patient participation and engagement, it remains a relatively new and under-researched field of study (Batalden et al., 2016), with debates over its exact definition (see Bovaird et al., 2015; Durose et al., 2014). For example, while the seminal work of Brudney and England (1983) identifies three broad levels of coproduction – individuals, groups and collectives, Palumbo (2016) argues that the individual level has dominated health-care-related interventions. In Bovaird and Loeffler's (2013) model, service-users' engagement is extended across four levels of involvement in service improvement: *co-commissioning, co-design, co-delivery and co-assessment*. However, even within this broadened remit, a narrow focus on the individual is maintained through emphasising relationships between service-users and providers within a process of enhancing health services. For example, a recent study of coproduction and self-management of chronic obstructive pulmonary disease (COPD) anchored co-design, co-delivery and co-assessment efforts to developing expert patients and carers through training in biomedical perspectives (Cramm & Nieboer, 2016). Despite this diversity, perspectives on coproduction are united by the belief that people should take active roles in their treatment and promotion of well-being, bolstering longstanding arguments that position community engagement as the future for better public health practice (Laverack, 2007, Public Health England, 2015).

In coproduction, like most community health engagement, the 'community' of interest is almost exclusively defined as patients. For example, Barello and colleagues (2014) highlight that across over 200 articles published globally, in most health domains (including mental health) engagement was defined as a means to improve individual actions around effective disease management, adherence to treatment, and individual participation with health promotion strategies (Barello et al., 2014: pg. 8). Attention to the wider community contexts which enable or hinder engagement, such as power, relationships, culture, context and resources, are almost entirely absent, despite work suggesting their critical importance elsewhere (Burgess, 2015; Becher & Wieling 2015, Cribb & Gewirtz, 2012; Rose & Kalathil, 2019).

In the absence of attention to these areas, coproduction most aligns with pragmatic forms of participation, which, though valued for their ability to respond to economic and resource-based challenges facing health systems (Bovaird et al., 2015) are strongly critiqued in other for their failures to impact on health outcomes (Rifkin, 2014), and deepening inequality between groups in complex settings (Campbell & Cornish, 2010). Practitioners in development studies have responded to these critiques by widening the boundaries of the community. For example, more radical approaches to community participation informed by emancipatory and social justice traditions (Freire, 1973) take a much broader stance on defining the community in health-related projects, taking geographical community as a starting point, and expanding outwards to map different groups who share commonalities, or desire to respond to a specific health or social concern. Within this wider perspective, service users are connected to constellations of communities, and issues such as power, culture and relationships emerge as key to driving health-related empowerment (Morgan, 2001; Laverack, 2013; Rifkin 2014).

Other barriers to successful coproduction include the different and often opposing perspectives held by patients and providers, which hinders the establishment of a shared vision (Palumbo & Trocciola, 2015). This, alongside unequal access to information about the outputs or issues around coproduced services, has been linked to low commitment to coproduction processes for some patients. For practitioners, risks associated with promoting increased patient engagement were linked to limited practitioner buy-ins into the process (Sharma et al., 2014). Such arguments suggest that while coproduction may theoretically create a platform to challenge the limited reflection on patient realities that characterise most health systems, in practice, this is not always achieved, as practitioners maintain the ability to set the terms and parameters of engagement. While Palmer et al.'s (2018) recent theoretical model asserts the importance of power, participation and empowerment factors to successful coproduction, they acknowledge that empirical evidence highlighting *how* such mechanisms contribute to success is scant.

Addressing these gaps will be critical for coproduction efforts with historically marginalised communities. In the UK, coproduction has been highlighted as a route to addressing the mental health inequalities facing minoritised communities (Lwembe et al., 2017), where longstanding overrepresentation of racially minoritized communities in UK mental health services (Mental Health Foundation, 2014) is linked to institutional, cultural and socio-economic factors (Fitch et al., 2010) inside and outside the healthcare system (Gajwani

et al., 2016). These factors drive higher prevalence of some mental health conditions, higher rates of involuntary detainment (Gajwani et al., 2016), higher rates of access to services via the criminal justice system (Ghali et al., 2013) and wide variations in the use and access to services (Bhui et al., 2003).

These realties embed an understandable fear and mistrust of mental health services among racially minoritiesd communities, resulting in lower engagement with mental health services (Chorlton et al., 2012). While some argue that coproduction has the potential to support the transformation of services by developing more equal relationships between them and professionals, others note that many attempts to address power imbalances are largely tokenistic (Ocloo & Matthews, 2016), including Salway and colleagues (2016) who argue ethnicity and health equity work is limited by an underappreciation of the intersectional nature of oppression. This has been re-affirmed within recent critiques of coproduction, including Fledderus and Honingh (2016) who identify that histories of oppression, silencing, and limited tangible outcomes from previous engagement are key factors limiting user engagement. For Rose and Kalathil (2019) most coproduction efforts remain rooted in the reproduction of mainstream knowledge systems, without questioning how they contributed to the same power imbalances that coproduction seeks to redress.

For coproduction targeting mental health inequalities among racially minoritised communities to meet these demands, it must enable engagement that avoids the pitfalls of failed participation approaches from the past. We contribute to such efforts by presenting a model of coproduction extending Loeffler and colleagues' (2013) four levels of involvement in service improvement, arguing for attention to the specific resources required to enable success in these areas. Drawing on findings from a multi-site ethnography, using participatory and qualitative methods, we highlight the presence of a foundational phase (phase zero), which attends to historical oppression, social and power inequalities facing black and other racially minoritized communities, and enabled coproduction processes to be viewed as more meaningful by all involved.

An important caveat: our proposed model reflects a working definition of 'the community' that extends beyond service-users, where a range of actors (some of which are service users, some of which are not) establish a community of practice where the goal is reducing mental health inequalities facing racially minoritized communities through systems change, rather than focusing on individual treatment outcomes. This is supported by the conceptualisations of community and coproduction used by the network at the heart of our ethnography (see methodology).

Study materials and methods

Research context

The People's Network[1] is a London-based network organisation which has built a programme of coproduced initiatives around mental health, in collaboration with statutory organisations, community-based organisations (CBOs), the voluntary sector and religious groups. Network members represent a range of ethnicities but are overwhelmingly from racially minoritised backgrounds, primarily Black African, Black Caribbean and Southeast Asian. The faith groups represented in the network include Black Pentecostal churches, Mosques and other Islamic community groups, the Church of England, a Hindu temple and related community groups. The network is based in one of the most unequal London boroughs, with high levels of income inequality; the gap between the rich and the poor ranks 26th out of 31 boroughs (Trust for London, 2020), premature mortality is the 4th worst in London, and life expectancy figures note men die 8.8 years earlier and women 4.9 years earlier than the London average (Trust for London, 2020; [Study Location] Council, 2019). Whilst the incidence of common mental health disorders among people 16 and over is slightly lower (18.8%) than the London average (19.3%), it still exceeds the England average (16.9%) (Public Health England, 2015). For more severe mental health disorders, incidence is higher, with 36.6% compared to 24.2%in the rest of England (Public Health England, 2011). Three categories of actors comprise the network – TPN, CBOs and statutory services; summarised in box 1. Supplementary materials

Methodology and methods

We completed a rapid multi-site ethnography to understand the dynamics driving the coproduction approach used by TPN. Multi-site ethnographies are well suited to investigations of complex engagements between space and place (Marcus, 1999), and enabled us to explore the contributions of a range of network partners, and interactions between systems, practices, people and contexts, using mixed methods. Despite concerns over the use of rapid ethnographies, we align with the perspectives Vougioukalou et al. (2019) who assert the value of ethnographic perspectives in evaluation studies, allowing better engagement with context and subjectivities. We take a pragmatic view of the application of ethnography

in health-related settings by applying a range of methods to preserve ethnographic qualities within narrow timeframes and focus, as suggested elsewhere (Vougioukalou et al., 2019).

Fifty-three individuals participated in a series of data collection methods including: participatory learning appraisal (PLA) workshops (n = 2) with CBO (n = 20) and statutory agency (n = 18) staff, Focus groups (n = 2), individual semi-structured interviews (n = 15) and 24 hours of unstructured observations of site visits and network events between October 2015 – January 2016. A participatory approach was adopted to create an even playing field for all actors to contribute to knowledge production, giving equal voice to the CBOs and TPN, rather than be guided by the researcher or statutory services perspectives of coproduction. This approach allowed for social and political factors, which shape relations and processes, to come to the forefront of the data (Beazley & Ennew, 2006).

Stage one of the data collection included a full-day workshop with TPN members that ended with a focus group. PLA methods (Rifkin & Pridmore, 2001) including organisational mapping, power venn diagrams and pair-wise ranking were used to map and explore relationships driving successful coproduction. Methods allowed us to explore how issues of power, control and identity were experienced within the network, and links to organisational culture, values and internally shared aims.

Phase two included unstructured observations and semi-structured interviews with TPN CBOs, using a topic guide. The interviews were crucial in gaining an insight into the historical development of the network (presented in phase zero of the model in Figure 1). Observations allowed exploration of current coproduction activities and any potential outcomes achieved by the coproduction work. This phase also included observations of service users participating in coproduction activities.

In *phase three* the focus was on statutory agencies linked to TPN. We conducted a workshop and semi-structured interviews. Participatory appraisal methods used included organisational mapping and vignettes to gain an understanding of statutory perspectives of coproduction and TPN. Semi-structured interviews with key figures who had worked with the network for over 8 years were guided by a topic guide. The third phase of the research informed the development of all three phases of the model (see Figure 1).

Ethics

The [author institution] University ethics committee deemed that the study did not require ethical clearance given the evaluation nature of the work, and low risk to participants. This position adheres to Health Research Authority (HRA) guidelines which stipulate that in contexts where a project is considered an audit, usual practice, surveillance or service evaluation in Public Health,

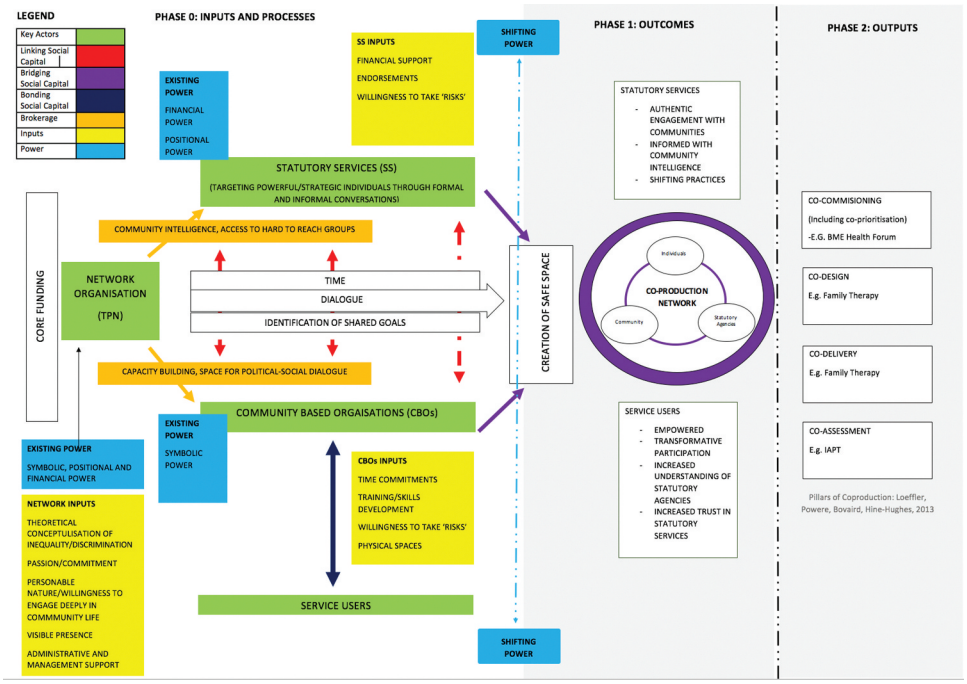

Figure 1. Phase zero: inputs and processes for enabling successful coproduction.

it should not be managed as research (HRA, 2016). To verify this, our study parameters were run through the National Ethics Research Service tool[2] run by the Health Research Authority, which confirmed the study was not research.

Prior to commencing data collection, our study design and methodology were approved by a local steering committee who oversee the delivery of coproduced services in the borough. Members of the steering committee included senior representatives from the Clinical Commissioning Group (CCG), NHS Mental Health Trust, Department of Public Health, head of a local CBO supporting the mental health of minoritised communities (and a service user) and the director of TPN. At the time of the research, the chair of the committee was a leading counsellor in the local government, an executive member of Adult Social Services and health, and chair of the health and well-being board. All research methods were deemed in line with ethical standards of their organisations and allowed to proceed. In line with American Psychological Association (APA) standards of good research, all participants were briefed regarding the aims of the evaluation, issues of consent, confidentiality, voluntary participation and right to withdraw from the study, and provided written consent. Generalised identifiers are used throughout to ensure anonymity.

Conceptual framework

Given the links between coproduction and participatory research, our analysis was guided by a desire to attend to the conditions necessary for meaningful health participation. We draw on community psychologists Campbell and Cornish (2010) contexts of successful participation and mobilisation, which argues that successful community encounters are only possible in the presence of enabling social contexts. They suggest the challenges faced by previous waves of community engagement (peer-support, expert-patients, etc.) can be addressed if programmes attend to three contexts rather than enable or hinder participation. The *material context* includes consideration of economic and structural resources that enable participation, for example, the ability to pay transportation costs; or the economic conditions that shape community life. *Symbolic contexts* include attention to the meaning, ideas and norms that influence the group status in society. This includes stigmatisation, or the power and respect afforded to certain actors based on social position. Finally, the *relational context*, which includes strategic relationships between groups that enable access to resources, and promote shared ownership and decision-making in relation to a collective goal. Though anchored to the analysis of HIV-related participation in the resource poor settings, we argue the relevance of these contexts to promoting mental health within typically excluded communities, given the double marginalisation they experience. Furthermore, material, relational and symbolic contexts represent the wider container where co-production exists – recognising the historical and contemporary challenges which may pre-determine the capacity for participation and transformation.

We also apply a multidimensional framework of power, rooted in its diffuse nature; operating at multiple levels of society, through multiple techniques and institutional practices (Foucault, 1980; Hook, 2007) producing a wide range of outcomes. As such, power is conceptualised beyond state structures or financial resources, as suggested by a Marxian approach to power, and viewed as a force working through relationships and social positions (Bourdieu, 1979; Cronin, 1996), manifested in quiet resistance (Scott, 1985). We also apply Bourdieu's (1979) notion of symbolic power, which shapes action through its ability to maintain social relationships, norms, and practices, often driving the decisions of others (Cronin, 1996). Symbolic forms of power may interact with other forms of power (e.g., material resources) or work independently.

Data analysis

Interviews and focus group discussions were translated verbatim by an external transcription company, and a sample (20%) was back-checked by the first author to confirm accuracy. All data, including observational notes, were analysed using Attride-Stirling's (2001) Thematic network analysis. Transcripts were read and hand-coded independently by both authors. Initial codes were discussed and organised into a thematic framework using a simple excel spreadsheet. This identified two broad processes: 1) Factors enabling coproduction, and 2) outcomes created through coproduction activities. We returned to the data, organising themes in relation to these over-arching ideas, creating a coding framework for each Finalisation of the coding framework on factors enabling coproduction was informed by our conceptual framework (see appendix 2 for the final coding framework). The second coding framework was purely data driven, and is reported elsewhere (Burgess & Choudary, 2017). Based on this analysis, we developed a model to illustrate the various inputs and contributions that provide the necessary conditions for coproduction to work within this network of actors, primarily from historically marginalised groups of this organisation (see Figure 1).

Results

While the model in Figure 1 presents a summary of the entire analysis, the findings in this paper focus on phase zero, and the inputs and processes which produced the appropriate contexts to enable coproduction with marginalised groups in our study. This is followed by a discussion of the outcomes from network efforts.

Our findings note contributions from each stakeholder group to a process that, over time, enables coproduction processes to be seen as meaningful engagement by people from marginalised backgrounds. These contributions established a new safe space and platform for engagement in co-production, co-design, and co-delivery of services including: the establishment of a BAME mental health forum (which included service users from racially excluded backgrounds), co-design activities including community network for family care, led by faith-based CBOs, and co-assessment activities. The remainder of this discussion elaborates on phase zero, which is described by the global theme: *psychosocial processes enabling coproduction with marginalised groups*. Full details on other outcomes can be found elsewhere (see Burgess & Choudary, 2017).

Symbolic contexts and their role in enabling coproduction

Across the network, groups made important contributions to laying the groundwork for coproduction activities. These reflected symbolic contexts – (i.e. power linked to social or cultural position) and occurred over many years. For example, TPN made critical contributions to the coproduction process, led by the efforts of a charismatic and critical director whose social location as someone from a racially marginalised background with post-graduate education (MSc/PhD) enabled him to engage in spaces where others could not – and be listened to. As noted by one participant:

> but he [TPN Director] wasn't afraid to have the conversations that at the best of times, people don't necessarily want to hear . . . but he maintained that and stuck to his belief and pushed through until he was able to help them to understand, actually I'm not here to cause you difficulty, I'm here to show that when we work together we end up with a better result. (CBO representative – interview)

The above also illustrates *how* the engagement took place; a commitment to conversation across groups. Thus highlighting that whilst his social location was vital to the coproduction process, persistence over time was also critical to his ability to build bridges with statutory partners.

The director's targeted engagement acknowledged the importance of positional power to successful coproduction; preliminary engagements specifically targeted high-ranking statutory officials, including executive directors and local government. Inviting statutory actors into community-owned spaces that service users identify as meaningful to their wellbeing, such as churches, mosques and temples, worked to level out power differentials in early encounters. By holding these early meetings outside spaces dominated by statutory power and practices (i.e. hospitals), historically marginalised groups were able to maintain and display symbolic power linked to their position and ownership of such spaces. As noted below:

> I remember the chair coming with his key officials and it was a really new thing for them to sit down in a room and just have a conversation with the community, where the community was able to talk and you felt the newness, you felt that we were making, we were now moving to a very different level (CBO representative – interview)

Importantly, both aspects of this engagement strategy occurred over many years. Participants with statutory leadership roles repeatedly drew on their positional power to endorse coproduction efforts in the early stages and later, champion new modes of working which devolved responsibility to communities.

> I think the most important contribution is being able to be seen there and supporting [coproduction] and if I can say, as a chief exec, I'll do it and then bring some of it back into the organisation, I think that that's a big thing. I think [my contribution] is raising that profile and with our board so there's obviously [more than]the money . . . (statutory services representative – interview)

CBO's actively contributed to enabling coproduction work. The symbolic power held by leaders of CBOs helped reduce barriers to service-users involvement and enabled discussions about mental health within the wider community. While culturally informed conceptualisations of mental health in black and other ethnic communities have been linked to low uptake of services (Fernando, 2014), in our study, these cultural frames were seen as the most meaningful platform for debates and discussions on mental wellbeing in a community that had rejected formal services:

> I think they've done more than we could ever do as a statutory agency, because they're able to talk and just, you see people giving, you go into the church there and there are people standing saying this is good for your mental health, people listen. If I say it well, they [the community] would say – 'yeah you would say that because you're from that lot over there', so I think

> that's a really big thing. (Statutory Services representative – interview)

By building a coproduction network that included key cultural leaders, it was possible to create a safe space where uncomfortable topics – including institutional racism in the mental health sector – could be discussed openly. For example, work co-led by Christian and Muslim faith leaders from racially excluded backgrounds, *the family therapy collective*, provided a clear endorsement to the wider communities of their acknowledgement of the importance of mental health services. Secondly, it addresses the underrepresentation of people of colour in mental health services, through creating a new community led pathways to care for service users from these backgrounds. Through the programme, Black Christian and Muslim faith leaders gained credentials as family therapy practitioners, meaning they could provide accredited treatment to their communities, in their communities. This shifts care physically – enabling it to be delivered in community spaces where historically marginalised groups may be more comfortable engaging in treatment. It also shifts care symbolically – changing the language and culture within which care is delivered, so it aligns with personhood in these communities. At the time of publication, two leaders from the Black pastors' group had completed their full qualification (MSc), enabling them to work within the NHS. As noted by one faith leader:

> I think that more and more there are numbers of people, communities who are often labelled as hard to reach. But I think now there are a few people from these communities in key positions, and it is recognised that we may have the potential to reach some of those communities where they are … .So for me I can see a movement of progression, we're not where we used to be, we're not where we would like to be, but we are having much more of an impact, … because there are some people who recognise that they can't do it on their own and they see us as having potential for being able to help them … (CBO – interview)

Over time, statutory bodies began to recognise and accept network contributions as critical to their success, driving them to take risks on new ideas and modes of working. Crucially, they recognised and valued the knowledge produced by CBOs as equal, and at times more valuable than their contributions. Beyond this, statutory bodies recognised that CBO contributions were actions to be appropriately and meaningfully compensated – and not simply expected because of altruism. As noted by one senior official:

> ….I think at the end of the day the community can do things cheaper than we could by commissioning them and it's only fair that if they are doing things that we are currently paying for, that we commission them. We can't just expect them to do it, do us favour continually without funding them. (Statutory services representative – interview)

This had positive impacts on CBOs, who began to see themselves differently, and as a result, contribute differently to co-produced spaces:

> I think a turning point came when we realised that those people, the people with the power, they've got needs too, they've got expenses, they've got quality targets, they've got all kinds of things . . . .and they [statutory bodies] are failing, run out of ideas, but we've got some solutions, we've got some ideas, so I think, for me, that was a turning point . . . . . and we stopped asking for things, saying we need it so, therefore, you should give it to us, because that didn't work . . . . . but saying we can help you do what you're supposed to be doing … (CBO representative – focus group)

Relational resources to enable coproduction activities

The development of trust and strong relationships across the network was seen as critical to enabling successful coproduction. This occurred through activities that promoted open dialogue at all levels of the partnership. For example, the TPN director was identified as a key to establishing relationships within the network. His own experiences of oppression enabled him to develop a common language among the different cultural groups represented by CBOs, while his higher educational training and knowledge of theory and formal health systems enabled him to translate community knowledge within professionalised knowledge spaces. This allowed him to build connections between actors on both sides.

> I have to say that if it wasn't for [his] tenacity and the determination and the bloody mindedness, excuse my language, breaking down barriers and upsetting some people and that, we probably wouldn't be where we are right now (CBO representative – focus group).

CBOs noted their ability to learn from the example set by TPN, and the ability to leverage one's position to meet with more powerful agents in statutory bodies to shift the power that the network had on the ground.

> Through that [coproduction] it's actually helped us to adjust and know how to, learn how to build relationships beyond just street-level officers - and this is a technique we had … .to start linking up with the people who are above them, who are more likely to never leave their chair [with an organisation], and that's what we literally actually do now, build

> a relationship with the leadership in the council (CBO representative – interview).

CBOs and statutory partners also noted the importance of ongoing commitment to developing coproduced activities over sustained time periods. Network members regularly gave their time to attend regular meetings, discussion, and training consistently directed at reducing black and other ethnic mental health inequalities over a decade.

> but what I like about coproduction is that it really gets, it's very slow and bit by bit, we all know, step by step, but it gets into the DNA of the whole system, so that even though it's slow, it gets there . . . but it links it up to where some of the power is, so we can add a better and more long lasting state of affairs . . . and I think faces I've known for over 12 years they're sticking together and keeping on and I think it's incredibly valuable and we have them to thank for an awful lot. (CBO representative – focus group)

The above also highlights the effectiveness of the TPN approach in establishing supportive relational contexts, through bridging gaps that hinder marginalised groups from feeling they contribute meaningfully to change.

Material resource contributions to enable coproduced activities

The findings highlighted the importance material resources to the coproduction network. Human resource contributions from statutory partners via secondments were used to support TPN in various ways – including support with applications for service delivery contracts, or advising on statutory processes and policy.

Crucially, TPN's core funding was provided through non-statutory funding routes by a national foundation with interests in systems change. TPN's human resource contributions to coproduced activities were enabled by core funding, allowing for shifting of people and funds to support new activities as needed. For example, they provided organisational support for meetings and events to bring all partners around the table, including regular network meetings, BAME mental health steering committees, and an annual conference on Black mental health for over a decade. Of equal importance were the financial resources provided by various statutory actors to fund initial coproduction activities. Funding was not linked to key performance indicators (KPIs) which allowed flexibility in supporting new activities backed by communities' perspectives on value, rather than strict evidence paradigms, such as performance management frameworks. For example, the family therapy collective described in the previous section, was funded by a grant from statutory bodies to TPN. The programme was supported for extension to other faith groups after initial evaluations based largely on trusting relationships established within the network:

> and I think this has been a very useful forum [network for family therapy] in terms of our work of me, as a pastor, learning from the Muslim brothers and sisters and also from [TPN Director] . . . because you're taking local community people out there, learning together and bringing this learning back into [the community], . . . I think that's why, for me, coproduction has been useful . . . they can also listen to us because our contributions have become [formalised] (CBO representative – focus group)

Outcome: creation of a safe space marked by equality and fairness between groups

These three types of resources established a common definition of coproduction that was more than just its composite parts (e.g. codesign or codelivery) but rather, something that displayed a shared commitment to wider systemic change. Below quotes from a CBO service user and network member, and a statutory partner affirm this:

> . . . for some people, coproduction is all about writing policies together . . . But to me, the thing this is really about is how do we get us working around the same goals and also move services out of statutory, to do things in a partnership with community and we share that belief that that can be done, together rather than separately and at a more strategic and a bigger network - (CBO representative – interview)

> Now that I've been involved in coproduction . . . it is really addressing issues and needs that would normally not have been addressed. It would just have got left or swept under the carpet (Statutory service representative – focus group)

Through developing this shared perspective, a new collective safe space emerged, helping to bridge gaps between partners who traditionally occupy very different spaces, and access to power and resources. Ultimately, the new safe space was defined by trust between groups with a history of negative experiences.

> If [the TPN director] had asked us to come together with these [statutory bodies] five years ago like this, would we have been interested? Maybe not . . . . but relationship is where it all starts and trust . . . So first of all we had to build this trust between us – it started with trusting (CBO representative – focus group)

These new spaces also enabled differences between CBO groups to be overcome – the identification of shared solidarity between different community stakeholders was recognised as a critical strategy for their efforts as noted by one Black Christian pastor:

> I have found it really useful to be able to listen to some of the things that you talk about, about your community and about the experiences of Muslims and about how Muslims are experiencing the world (CBO representative – focus group)

Another example of a safe space was the community conference on Black mental health, coordinated by TPN. The conferences were created to provide opportunities to discuss the wider structural drivers linked to mental health inequalities: racism in services, inequalities, poverty and violence in communities. Observational data highlighted the openness of these spaces – where sensitive issues were being debated between senior leaders from statutory bodies and community members during question and answer sessions. Our observations noted that racism and poor allocation of resources were the primary concerns that statutory agencies were asked to respond to. However, it was observed that these discussions were not confrontational in nature but marked by a sense of shared solidarity over the issue. Statutory organisations were praised for their willingness to bear witness to the difficult history between racially excluded communities and health systems at these events, which contributed to a process where longstanding power asymmetries are recognised, and then over time, addressed.

> Well, just going back to when we did the first conference or the first few in fact, they [statutory bodies] were invited and we sat and listened, they were the ones in control .... Whereas now it's turned right around, so that they come and they listen to us and they take away some of the learnings and then work with us to implement changes and so on. So for me I guess I've seen that myself in the complete shift ... (CBO representative – focus group)

The ability for agencies to be held accountable for their previous decisions and actions within the community was ultimately an outcome of phase zero, and the existence of the network. Over time as CBOs felt more empowered, they felt able to openly express themselves on topics they had not been able to discuss in the past.

> ... (with) coproduction I think is something interesting – there has to be some giving away of power, but there also has to be something about accepting power and accepting responsibility (Statutory services representative – focus group)

Discussion

Our paper confirms recent assertions that coproduction with marginalised groups can only be meaningful through long-term engagement. Through attention to material, relational and symbolic resources of participation, historical barriers and unequal power dynamics between actors can begin to shift. In our study, these resources contributed to the development of relationships, collaborative projects and service user engagement for 4 years before the first 'official' coproduction activity began in 2012. Deliberate slow engagement differentiates the TPN model from other models of coproduction in the literature and has been recently championed in coproduction efforts with other marginalised groups around Sickle cell disease (Miles et al., 2018). While some models seem to suggest that engagement, relationship making and development of safe spaces can occur simultaneously within coproduction activities (see Palmer et al., 2018), our model highlights the critical value of focused attention in redressing longstanding differences between groups long before this begins.

Recent evidence emphasises structural contributions to safe spaces for coproduction, including transportation, food and care costs to enable participation of groups for whom these issues form barriers to engagement (Ní Shé et al., 2019). However, in phase zero, the function of the safe space also hinges on establishing psychological notions of safety – where typically excluded and marginalised voices feel safe speaking out on topics labelled too sensitive, or beyond the remit of health service discussions. This focus highlights phase zero's ability to achieve what Rose and Kalathil (2019) identify as the 'third-space'; a post-colonial perspective describing relationships that can produce new meanings and representations of groups traditionally separated by cultural and power differences. While they argue that this is impossible in most mental health coproduction projects targeting marginalised groups, our study suggests otherwise. As a result of phase zero, power is redistributed across partners because no single actor has full responsibility over outcomes: TPN's core funding, provides independence from statutory boundaries continuing to work in the background. CBOs human, physical and cultural resource contributions enable community change, and activities are jointly funded by constellations of statutory partners (i.e. local government and health services). Thus expanding the remit for which voices are listened to, and how seriously they are taken in decision-making.

TPN's work linking actors in the health system across power levels (i.e. between potential service users, communities and health services), and between groups with similar histories of shared oppression (i.e. Black Caribbean and Muslim communities) is a key part of phase zero. This process of facilitating and supporting dialogue, engagement and action through promoting shared relationships and languages reflects the sociological process of brokerage (Stovel & Shaw, 2012). In health contexts, this

is often linked to cultural brokerage (McKenna et al., 2015) where the goal is to translate health-related praxis across cultural languages. Brokerage in our study was multi-directional, across a constellation of actors and included attention to structural contexts, such as marginalisation within health services, alongside practical strategies for linking resources contributed by each group towards the shared and goal of improving the mental health of racially minoritised groups. These efforts bring the goal of brokerage for co-production more in line with Putnam's (2000) notion of bridging social capital, where ties are built beyond one's own community, in order to access resources to achieve a particular goal. This more systemic approach to brokerage has been noted in health promotion efforts in other European settings, including the Netherlands, which led to similar improvements in collaboration, community participation and administrative support (Harting et al., 2011).

Phase zero is marked by the relatively limited presence of service users. In this study, service user engagement cannot begin immediately; a history of abuse at the hands of health services is recognised as the boundary and issue that must be acknowledged, before forcing that type of engagement. Instead, many service users linked into the network through membership to CBOs – and events and activities they lead. Thus, non-mental health related CBOs became bridges between service user communities and statutory actors, relaying their views and perspectives outwards, until, service users felt the space was safe to enter. This highlights CBOs brokerage as linking social capital (Woolcock, 1998) – moving ideas between communities to facilitate the transfer of resources to new spaces. Elsewhere, this has been shown as building trust, first in small ways that support the development of trust in an affiliate organisation linked to that key actors for example a recent study of aboriginal mental health in Australia by McKenna et al. (2015) highlights the importance of liaison officers for building trust and belief in the ability of previously harmful institutions to change for the better.

The abovementioned engagement is enabled by a wider definition of 'community' in relation to mental health services than is typically seen in the literature (Elias et al., 2020). TPN and their partners exemplify a community of practice anchored to and representing multiple positionalities, where service user/provider identities are one part of a broader picture. This definition acknowledges two things. First, that a wide range of actors, with differing social positions and access to various forms of power, have the ability to shape health enabling action in a community of place. Second, that service users may draw on a range of identities to inform health decisions. For those whose marginalisation is linked to negative experiences of violence and racism, rejection of traditional service spaces is logical (Kinouani, 2020). For others, a rejection of the service user identity itself may occur, in exchange for a more complex notion of personhood than the discourse allows (Foster, 2007; Speed, 2006). Such diversity does not negate the formation of community action, but, rather, forms an incredibly meaningful basis for community as articulated by Howarth and others (2015). The interdependence of actors around a common activity demands not just a shared project, but also acknowledges that knowledge construction is motivated by varied interests.

This was achieved in our study because various relationships developed in phase zero were given the time to develop. In dealing with issues of power and privilege, shifting perspectives and practices between historically opposing groups requires contact over time. While social psychological frameworks assert that repeated contact between opposing groups can reduce prejudice over time (see Pettigrew, et al., 2007), this must be quality contact – marked by meaningful engagement. In our study, contact (mediated by the TPN director as lead broker) was organised around strategic conversations highlighting mutual gains from the parties' engagement with each other.

Where this contact occurred was also important. Discussions between CBOs and statutory partners were always held in community owned spaces – churches, mosques and community centres. Social installations theory (Lahlou, 2017) draws our attention to the ability for the psychological, relational and institutional structures within physical space to determine who has the ability to speak, be heard, and what is possible in terms of speech and action. By working in community-owned spaces instead of statutory sites, the network acknowledges and fractures the power of norms and markings of power to intimidate marginalised groups and limit their ability to feel like they belong, enabling community contributions to become meaningful.

Statutory partners' engagement was not totally driven by social justice aims – they benefited through drawing on local expertise and cultural capital held by community leaders, who provided access to intelligence about groups traditionally labelled 'hard to reach'. However, within this study, rather than feeling excluded and overlooked by professionals as seen in other studies of coproduction with marginalised groups (Fledderus & Honingh, 2016), because of a long-standing engagement with community partners, statutory providers acknowledged and recognised local strengths, bringing typically 'excluded' groups into more active roles. This was matched by funding to support community-led ideas, or remuneration for community contributions to coproduction efforts. This was re-affirming for communities themselves,

who viewed themselves as valuable to the health infrastructure, while avoiding an overreliance on volunteerism in response to resource challenges, which has been problematic in other settings (Burgess, 2014).

Our findings have important implications for future coproduction efforts with vulnerable and marginalised groups. First, it suggests that explicit focus must be placed on mapping existing power relationships between groups, to understand and identify potential barriers to true participation and engagement. This includes acknowledging forms of power beyond the material – with emphasis on identifying and supporting skills, and resources marginalised groups already have at their disposal, to support their future use. Second, it suggests that time-bound project outcomes may undermine the ability of coproduction efforts to gain meaning for marginalised groups. In spaces where inequity between partners is the starting point, a focus on outcomes, should be exchanged for a focus on the process. This would require invoking principles bound up in transformative participatory frameworks – where participation is not an end, but the means of enabling historically marginalised groups to speak, be heard, and supported in addressing structurally embedded inequities.

We recognise some limitations to this model, and our wider study. Firstly, while time is critical to phase zero, it must be acknowledged that time may not be afforded to organisations bound by contractual obligations. Thus, a reimagination of what coproduction entails is required by the funders and public bodies who champion coproduction for marginalised groups, acknowledging material resources to allow for the development of safe spaces to reap the longer term benefits of authentically engaging communities.

Secondly, the evaluation of TPN occurred after phase zero had been completed, and thus we could not observe tensions which may have occurred at earlier stages of the network's development. Given the complex power, dynamics at play within stakeholder engagement, tension is inevitable. However, the relational resources highlighted in our model could also be drawn upon to mitigate and work through tensions, as they also have the possibilities for opening up spaces for reflexive dialogue between stakeholders.

Thirdly, we recognise that the limited presence of service-users in our sample, and within the network, may be considered a limitation. However, the UK has a well-documented history of racism and exclusion of vulnerable populations within mental health services, particularly for people of Black Caribbean and Black African descent (Fernando, 2010). As such, their absence highlights the need to explore and understand the readiness of marginalised groups to participate in coproduction activities, through meaningful reflection on previous and ongoing experiences of oppression and marginalisation at systemic and relational levels (Rose & Kalathil, 2019). While we were not surprised by accounts of Black and other ethnic service users' avoidance of events during the early stages of the network, our findings illuminate the value of a less described form of coproduction, where groups who may not suffer from a condition themselves, participate in improving services for others because of perceived collective benefits (Bovarid et al., 2015). The coproduction efforts analysed herein, speak to a desire to establish spaces that are more welcoming and positive for people who experienced compounded marginalisation within services. Network members of Black and other minority backgrounds draw on their own experiences of racial marginalisation in the UK as a starting point to begin the work to transform and translate power structures to make services more welcoming to racially minoritized service users. Crucially, the hesitance of service users, to join such activities, is not a sign of failure, but the starting point for improvement. Phase zero emerges as a real-world example of Fraser, (1990) counter-public sphere for mental health, allowing historically marginalised groups to share perspectives, experiences and feel their voices are welcome, before engaging in wider debates where perspectives may hold less weight.

Through active brokerage, the coproduction approach used by this network leverages this space for action on both ends, affecting changes not just for service users, but wider communities and statutory spaces where decision-making typically occurs. This is the greatest potential for coproduction of this kind – that it attends to making all spaces safe for health-related participation, through transforming the people who hold power, so that they begin to see the wider value of such action. This is mandatory if we are to move beyond studying experiences of marginality in health, and towards ending them.

Notes

1. Organisation name has been changed to ensure anonymity of interview participants.
2. See: http://www.hra-decisiontools.org.uk/research/index.html

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References

Attride-Stirling, J. (2001). Thematic networks: An analytic tool for qualitative research. *Qualitative Research*, *1*(3), 385–405. https://doi.org/10.1177/146879410100100307

Barello, S., Graffigna, G., Vegni, E., & Bosio, A. C. (2014). The challenges of conceptualizing patient engagement in health care: a lexicographic literature review. *Journal of Participatory Medicine*, *6*(11), 259–267.

Barnett, P., Mackay, E., Matthews, H., Gate, R., Greenwood, H., Ariyo, K., Bhui, K., Halvorsrud, K., Pilling, S., & Smith, S. (2019). Ethnic variations in compulsory detention under the Mental Health Act: A systematic review and meta-analysis of international data. *The Lancet Psychiatry*, *6*(4), 305–317. https://doi.org/10.1016/S2215-0366(19)30027-6

Batalden, M., Batalden, P., Margolis, P., Seid, M., Armstrong, G., Opipari-Arrigan, L., & Hartung, H. (2016). Coproduction of healthcare service. *BMJ Quality & Safety*, *25*(7), 509–517. https://doi.org/10.1136/bmjqs-2015-004315

Beazley, H., & Ennew, J. (2006). Participatory methods and approaches: Tackling the two tyrannies. *Doing Development Research*, 189–199.

Becher, E. H., & Wieling, E. (2015). The intersections of culture and power in clinician and interpreter relationships: A qualitative study. *Cultural Diversity and Ethnic Minority Psychology*, *21*(3), 450.

Bhui, K., Stansfeld, S., Hull, S., Priebe, S., Mole, F., & Feder, G. (2003). Ethnic variations in pathways to and use of specialist mental health services in the UK: A systematic review. *The British Journal of Psychiatry*, *182*(2), 105–116. https://doi.org/10.1192/bjp.182.2.105

Bourdieu, P. (1979). Symbolic power. *Critique of Anthropology*, *4*(13–14), 77–85. https://doi.org/10.1177/0308275X7900401307 https://www.wzb.eu/system/files/docs/dsi/af/rifkin_2012_rhetoric_to_reality_a_review_of_cp_and_health_policy.pdf

Bovaird, T., & Loeffler, E. (2012). *We're all in this together: User and community co-production of public outcomes*. Institute of Local Government Studies.

Bovaird, T., & Loeffler, E. (2013). *We're all in this together: harnessing user and community co-production of public outcomes*. Birmingham: Institute of Local Government Studies, University of Birmingham, 1(2013), 15.

Bovaird, T., Van Ryzin, G. G., Loeffler, E., & Parrado, S. (2015). Activating citizens to participate in collective co-production of public services. *Journal of Social Policy*, *44*(1), 1–23. https://doi.org/10.1017/S0047279414000567

Brudney, J. L., & England, R. E. (1983). Toward a definition of the coproduction concept. *Public Administration Review*, *43*(1), 59–65. https://doi.org/10.2307/975300

Burgess, R., & Choudary, N. (2017). *Coproduction from Theory to Practice: Wandsworth Community Empowerment Network: An Evaluation Report*. WCEN.

Burgess, R. A. (2014). 'It depends on them'–exploring order and disjuncture in responding to the local needs of AIDS-affected communities in the Kingdom of Swaziland. *Journal of Development Studies*, *50*(4), 467–480. https://doi.org/10.1080/00220388.2013.858123

Burgess, R. A. (2015). Supporting mental health in South African HIV-affected communities: primary health care professionals' understandings and responses. *Health Policy and Planning*, *30*(7), 917–927.

Campbell, C., & Cornish, F. (2010). Towards a "fourth generation" of approaches to HIV/AIDS management: Creating contexts for effective community mobilisation. *AIDS Care*, *22*(sup2), 1569–1579. https://doi.org/10.1080/09540121.2010.525812

Chorlton, E., McKenzie, K., Morgan, C., & Doody, G. (2012). Course and outcome of psychosis in black Caribbean populations and other ethnic groups living in the UK: A systematic review. *International Journal of Social Psychiatry*, *58*(4), 400–408. https://doi.org/10.1177/0020764011403070

Cramm, J. M., & Nieboer, A. P. (2016). Is "disease management" the answer to our problems? No! Population health management and (disease) prevention require "management of overall well-being". *BMC health services research*, *16*(1), 1–6.

Cribb, A., & Gewirtz, S. (2012). New welfare ethics and the remaking of moral identities in an era of user involvement. *Globalisation, Societies and Education*, *10*(4), 507–517. https://doi.org/10.1080/14767724.2012.735155

Cronin, C. (1996). Bourdieu and Foucault on power and modernity. *Philosophy & Social Criticism*, *22*(6), 55–85. https://doi.org/10.1177/019145379602200603

Durose, C., Mangan, C., Needham, C., & Rees, J. (2014). *Evaluating co-production: pragmatic approaches to building the evidence base*.

Elias, L., Singh, A., & Burgess, R. A. (2020). In search of 'community': A critical review of 'community' mental health services for women in African settings. *Health Policy & Planning*, *36*(2), 205–217. https://doi.org/10.1093/heapol/czaa140

Fernando, S. (2010). *Mental health, race and culture*. Macmillan International Higher Education.

Fernando, S. (2014). Globalization of psychiatry–A barrier to mental health development. *International Review of Psychiatry*, *26*(5), 551–557.

Fitch, C., Chaplin, R., & Tulloch, S. (2010). The Debt and Mental Health Evidence Form: a tool for health professionals and lenders dealing with customers with self-reported mental health problems. *The Psychiatrist*, *34*(3), 95–100.

Fledderus, J., & Honingh, M. (2016). Why people co-produce within activation services: The necessity of motivation and trust–an investigation of selection biases in a municipal activation programme in the Netherlands. *International Review of Administrative Sciences*, *82*(1), 69–87. https://doi.org/10.1177/0020852314566006

Foster, J. L. (2007). *Journeys through mental illness: Client experiences and understandings of mental distress*. Macmillan International Higher Education.

Foucault, M. (1980). Truth and power. In C. Gordon Ed., *Power/knowledge. Selected Interviews & Other Writings by*

Michel Foucault, 1972-1977. Vintage. (pp. 109–133). Havester.

Fraser, N. (1990). Rethinking the public sphere: A contribution to the critique of actually existing democracy. *Social Text*, (25/26), 56–80. https://doi.org/10.2307/466240

Freire, P. (1973). Education for critical consciousness. London: Bloomsbury Publishing.

Gajwani, R., Parsons, H., Birchwood, M., & Singh, S. P. (2016). Ethnicity and detention: Are Black and minority ethnic (BME) groups disproportionately detained under the Mental Health Act 2007? *Social Psychiatry and Psychiatric Epidemiology*, *51*(5), 703–711. https://doi.org/10.1007/s00127-016-1181-z

Ghali, S., Fisher, H. L., Joyce, J., Major, B., Hobbs, L., Soni, S., Bloy, S., Papada, P., Lawrence, J., Bloy, S., Marlowe, K., Aitchison, K. J., Power, P., Johnson, S., & Chisholm, B. (2013). Ethnic variations in pathways into early intervention services for psychosis. *The British Journal of Psychiatry*, *202*(4), 277–283. https://doi.org/10.1192/bjp.bp.111.097865

Haldane, V., Chuah, F. L., Srivastava, A., Singh, S. R., Koh, G. C., Seng, C. K., & Legido-Quigley, H. (2019). Community participation in health services development, implementation, and evaluation: A systematic review of empowerment, health, community, and process outcomes. *PloS One*, *14*(5), 5. https://doi.org/10.1371/journal.pone.0216112

Harting, J., Kunst, A. E., Kwan, A., & Stronks, K. (2011). A 'health broker'role as a catalyst of change to promote health: An experiment in deprived Dutch neighbourhoods. *Health Promotion International*, *26*(1), 65–81. https://doi.org/10.1093/heapro/daq069

Hook, D. (2007). Discourse, knowledge, materiality, history: Foucault and discourse analysis. In *Foucault, psychology and the analytics of power* (pp. 100–137). London: Palgrave Macmillan.

Howarth C, Cornish F, Gillespie A. 2015. " Making community: diversity, movement and interdependence," In Sammut, G., Andreouli, E., Gaskell, G., and Valsiner, J. (eds.), *The Cambridge Handbook of Social Representations* (pp. 179–190). Cambridge: Cambridge University Press (Cambridge Handbooks in Psychology). https://doi.org/10.1017/CBO9781107323650.015 .

Kickbusch, I., & Gleicher, D. (2012). *Governance for health in the 21st century*. World Health Organization. Regional Office for Europe.

King, M., Smith, A., & Gracey, M. (2009). Indigenous health part 2: The underlying causes of the health gap. *The Lancet*, *374* (9683), 76–85. https://doi.org/10.1016/S0140-6736(09)60827-8

Kinouani, G. (2020). Silencing, power and racial trauma in groups. *Group Analysis*, *53*(2), 145–161. https://doi.org/10.1177/0533316420908974

Kirkbride, J. B., Barker, D., Cowden, F., Stamps, R., Yang, M., Jones, P. B., & Coid, J. W. (2008). Psychoses, ethnicity and socioeconomic status. *The British Journal of Psychiatry*, *193* (1), 18–24. https://doi.org/10.1192/bjp.bp.107.041566

Lahlou, S. (2017). How agency is distributed through installations. *Distributed agency*, 221–229.

Laverack, G. (2007). Health promotion practice: building empowered communities. UK: McGraw-Hill Education.

Laverack, G. (2013). Individualism or activism for health in hard times? *Journal of Public Health*, *21*(4), 385–386. https://doi.org/10.1007/s10389-013-0554-y

Lwembe, S., Green, S. A., Chigwende, J., Ojwang, T., & Dennis, R. (2017). Co-production as an approach to developing stakeholder partnerships to reduce mental health inequalities: An evaluation of a pilot service. *Primary Health Care Research & Development*, *18*(1), 14–23. https://doi.org/10.1017/S1463423616000141

Marcus, G. E. (1999). *Critical anthropology now: Unexpected contexts, shifting constituencies, changing agendas*. Sar Press.

McKenna, B., Fernbacher, S., Furness, T., & Hannon, M. (2015). "Cultural brokerage" and beyond: Piloting the role of an urban Aboriginal Mental Health Liaison Officer. *BMC Public Health*, *15*(1), 881. https://doi.org/10.1186/s12889-015-2221-4

Mental Health Foundation .(2014). Black and Minority Ethnic Communities [Online]. http://www.mentalhealth.org.uk/helpinformation/mental-healtha-z/B/BME-communities/

Miles, S., Renedo, A., & Marston, C. (2018). 'Slow co-production' for deeper patient involvement in health care. *The Journal of Health Design*, *3* (1), 57–62. 2206-785X. https://doi.org/10.21853/JHD.2018.39

Morgan, L. M. (2001). Community participation in health: Perpetual allure, persistent challenge. *Health Policy and Planning*, *16*(3), 221–230. https://doi.org/10.1093/heapol/16.3.221

NHS, Health Research, Authority (HRA). 2016. Is my study research? [online decision tool]. Retreived April 19, 2021 from http://www.hra-decisiontools.org.uk/research/

Ní Shé, É., Morton, S., Lambert, V., Ní Cheallaigh, C., Lacey, V., Dunn, E., Loughnane, C., O'Connor, J., McCann, A., Adshead, M., & Kroll, T. (2019). Clarifying the mechanisms and resources that enable the reciprocal involvement of seldom heard groups in health and social care research: A collaborative rapid realist review process. *Health Expectations*, *22*(3), 298–306. https://doi.org/10.1111/hex.12865

Ocloo, J., & Matthews, R. (2016). From tokenism to empowerment: Progressing patient and public involvement in healthcare improvement. *BMJ Quality & Safety*, *25*(8), 626–632. https://doi.org/10.1136/bmjqs-2015-004839

Palmer, V. J., Weavell, W., Callander, R., Piper, D., Richard, L., Maher, L., . . . Iedema, R. (2018). The Participatory Zeitgeist: An explanatory theoretical model of change in an era of coproduction and codesign in healthcare improvement. *Medical Humanities 45*(3), 247–257. medhum-2017.Epub 2018 Jun 28. https://doi.org/10.1136medhum-2017-011398 .

Palumbo, R. (2016). Contextualizing co-production of health care: A systematic literature review. *International Journal of Public Sector Management*, *29*(1), 72–90. https://doi.org/10.1108/IJPSM-07-2015-0125

Palumbo, R., & Trocciola, G. (2015). Co-producing services to enhance cultural heritage, The role of coproduction in improving the quality of tourism services. In *Sinergie Referred Conference Proceedings, Heritage, Management e Impresa*: *quali sinergie* (pp. 77–90).

Pettigrew, T. F., Christ, O., Wagner, U., & Stellmacher, J. (2007). Direct and indirect intergroup contact effects on prejudice: A normative interpretation. *International Journal of intercultural relations*, *31*(4), 411–425.

Public Health England (2011) *Mental Health and Wellbeing Joint Strategic Needs Assessment*, viewed on 12. 01.20. Public health England. https://fingertips.phe.org.uk/mh-jsna#page [studylocation]

Public Health England (2015) *Mental health and wellbeing joint strategic needs assessment*, viewed on 12. 01.20.

Public health england. https://fingertips.phe.org.uk/mh-jsna#page[studylocation]
Putnam, R. D. (2000). *Bowling alone*: *The collapse and revival of American community*. Simon and schuster.
Rifkin, S. B., & Pridmore, P. (2001). Partners in planning: information, participation and empowerment. London: Macmillan.
Rifkin SB. 2014. Translating Rhetoric to Reality: A Review of Community Participation in Health Policy over the Last 60 Years. Berlin: WZB Social Science Center. Retrieved April 19, 2021 from, https://www.wzb.eu/system/files/docs/dsi/af/rifkin_2012_rhetoric_to_reality_a_review_of_cp_and_health_policy.pdf
Rose, D. (2008). Madness strikes back. *Journal of Community & Applied Social Psychology*, *18*(6), 638–644. https://doi.org/10.1002/casp.981
Rose, D., & Kalathil, J. (2019). Power, privilege and knowledge: The untenable promise of co-production in mental 'health'. *Frontiers in Sociology*, *4*, 57. https://doi.org/10.3389/fsoc.2019.00057
Salway, S., Mir, G., Turner, D., Ellison, G. T., Carter, L., & Gerrish, K. (2016). Obstacles to "race equality" in the English National Health Service: Insights from the healthcare commissioning arena. *Social Science & Medicine*, *152*, 102–110.
Scott, J. C. (1985). *Weapons of the weak*: *Everyday forms of peasant resistance*. yale university Press.
Sharma, S., Conduit, J., & Hill, S. R. (2014). Organisational capabilities for customer participation in health care service innovation. *Australasian Marketing Journal (AMJ)*, *22*(3), 179–188. https://doi.org/10.1016/j.ausmj.2014.08.002
[Study Location] Council (2019) *Joint Strategic Needs Assessment*, viewed 12. 01.20.https://www.[studylocation].gov.uk/the-council/council-decision-making/[studylocation]-health-and-wellbeing-board/joint-strategic-needs-assessment-jsna/
Speed, E. (2006). Patients, consumers and survivors: A case study of mental health service user discourses. *Social science & medicine*, *62*(1), 28–38.
Stovel, K., & Shaw, L. (2012). Brokerage. *Annual review of sociology*, *38*, 139–158.
Sweeney, A., Gillard, S., Wykes, T., & Rose, D. (2015). The role of fear in mental health service users' experiences: A qualitative exploration. *Social Psychiatry and Psychiatric Epidemiology*, *50*(7), 1079–1087. https://doi.org/10.1007/s00127-015-1028-z
Trust for London (2020) *Poverty Profiles*, viewed 12. 01.20. https://www.trustforlondon.org.uk/data/boroughs/[studylocation]-poverty-and-inequality-indicators/
Vougioukalou, S., Boaz, A., Gager, M., & Locock, L. (2019). The contribution of ethnography to the evaluation of quality improvement in hospital settings: Reflections on observing co-design in intensive care units and lung cancer pathways in the UK. *Anthropology & Medicine*, *26*(1), 18–32. https://doi.org/10.1080/13648470.2018.1507104
Wang, P. S., Lane, M., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Twelve-month use of mental health services in the United States: Results from the National Comorbidity Survey Replication. *Archives of General Psychiatry*, *62*(6), 629–640. https://doi.org/10.1001/archpsyc.62.6.629
Woolcock, M. (1998). Social capital and economic development: Toward a theoretical synthesis and policy framework. *Theory and society*, *27*(2), 151–208.