Funded by the Erasmus + program of the European Union

The STRENCO Logic Model for tripartite working in mental health

Output 3

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Introduction

The STRENCO Logic Model, is a Tripartite Model (hereafter referred to as the STRENCO Logic Model) for working in mental health in a more co-produced way (Figure 1) is presented in this document. A detailed, in-depth overview of the model, how the model was created and the data and analysis on which it is based, is available in English in the supporting documentation for the project. The model represents the product of Output 3 in the STRENCO Project, which seeks to strengthen competencies for working in mental health.

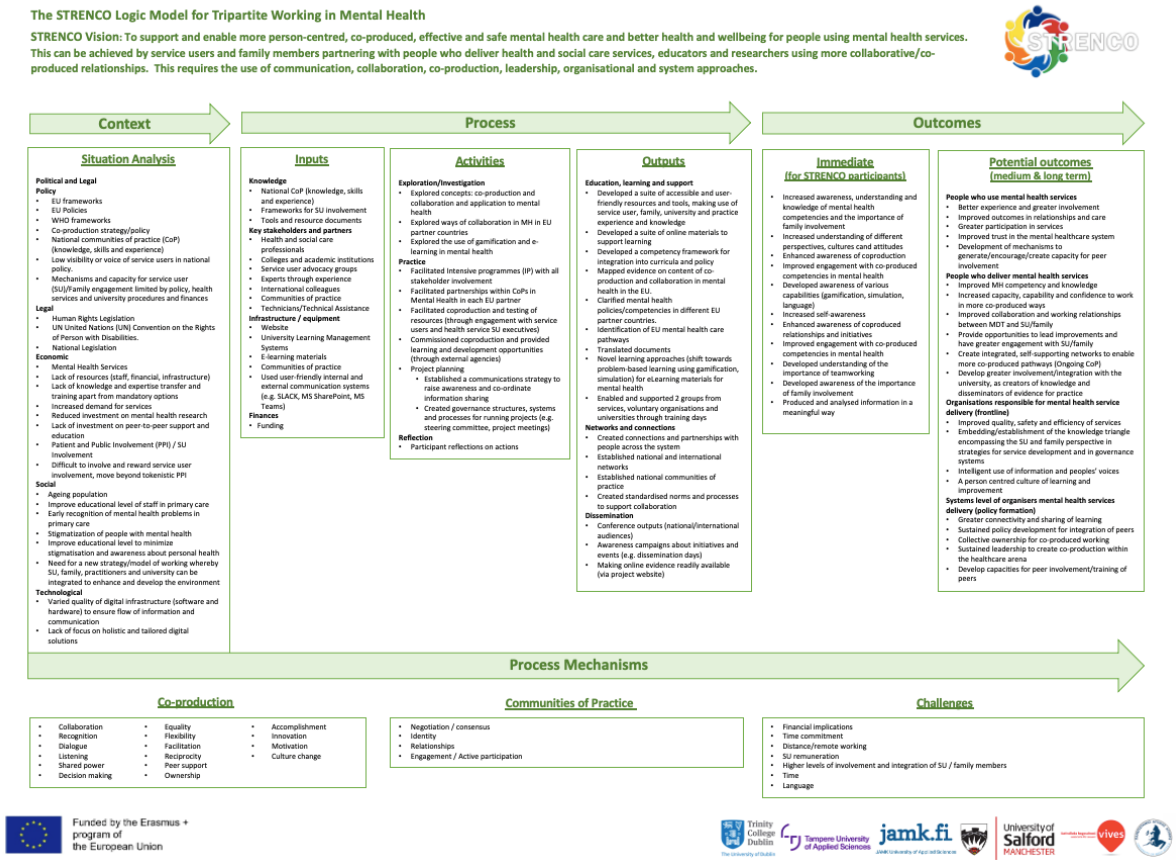


Figure 1 STRENCO Logic Model (see Appendix 1 for larger version)

The STRENCO Vision was to support and enable more person-centred, co-produced, effective and safe mental health care and better health and wellbeing for people using mental health services. It is underpinned by the belief that this can be achieved by service users and family members partnering with people who deliver health and social care services, educators, researchers and students using more collaborative/co-produced relationships. This requires the use of communication, collaboration, co-production, leadership, organisational and system approaches. These are the foundational principles that we have endeavoured to work by, over the course of the project.

The STRENCO Logic Model for Tripartite Working provides a snapshot of the feasibility of working in more co-produced ways to achieve greater inclusiveness of service users, family members, carers, experts by experience, clinicians, academics and students in relation to decision making processes, care, policy and research, which is aspired for mental health.

The development of the model was conceived in the context of EU policy emphasising the role of research, education and practice as co-creators in developing new approaches for working (knowledge triangle). In some countries co-production is written into national policy frameworks, whilst in others the integration of service users is limited to involvement in research projects, with the integration of service users and family members into mental health service development, delivery, evaluation and research a work in progress.

Whilst co-production forms part of discussions in regards to mental health services, few examples of how this can be done by involving all dimensions in the knowledge triangle currently exist. The STRENCO Logic Model for tripartite working (Figure 1) extends current evidence by providing pragmatic guidance on how to co-produce in mental health (Slay & Stephens, 2013; NDTi, 2016).

In making the proposal to create a Tripartite Model for working, the partners agreed and put forward a method where all stakeholders in the mental health conversation could be involved in the co-creation of knowledge and learning that might strengthen and improve competencies in mental health. An approach, drawing from the principles of participatory action research was adopted. This approach proposed the development of Communities of Practice (CoPs) comprising service users, family members, carers, experts by experience, clinicians, academics and students in each of the six partner institutions in the five countries. These CoPs fed into the central project as 'think tanks', both for the development of the Outputs on the project and for the running of the associated Intensive Programmes for students and teachers. Through our learning in these Communities of Practice, they have become the keystone of the STRENCO Logic Model and as a way of working.

The STRENCO Logic Model

The STRENCO Logic Model highlights how context, process and outcomes are intertwined within co-production. The process of working in a co-produced manner can be visualised as a jigsaw with the key components (pieces) including context, process and outcomes. The process mechanism should be considered as key factors that influence co-production.

Context (Situational Analysis)

'Context' is a pervasive force that is influential to the success of projects. It captures the setting and realities in which the programmes are developed to understand potential implications for future. In the STRENCO project, the team used the PEST analysis as a practical framework to capture political, legal, economic, social and technological evidence and team experience at both national and international levels. It captured understanding of geographical variations in policy, co-production, variety of funding models and service provision in which the STRENCO project operated. Then, as the project progressed, analysis of IP weeks reflections highlighted the variety of policy, healthcare systems and overlapping in mental health competencies across countries.

Process

The 'Process' highlights the inputs and activities required to trigger the outputs which can be utilised in developing more co-produced ways of working in mental health. These identify the use of national and international policies and frameworks, key stakeholders for involvement, infrastructural elements and importantly the resources required for development of these approaches. Process also includes activities or things that were/can be accomplished within the realm of co-produced working. These are represented in the concepts of investigation, practice and reflection. The final element of process are outputs. Outputs represent the results of activity. In this regard, the model identifies the importance of education, learning and support, making connections and establishing networks, and formats for the dissemination of information, as key components in the model's outputs.

Outcomes

The third element of the model are the outcomes, reported as immediate and long-term. Analysis of IP participants reflections demonstrated that by following the above working 'Process' triggered short term outcomes for participants, who reported increased awareness, understanding and knowledge of mental health competencies and the importance of family involvement. Participants improved engagement with co-produced competencies whilst developing awareness of co-production, coproduced relationships and initiatives. In longer term, working in a co-produced way is expected to generate positive outcomes at micro and macro level (people who use the services, people who deliver mental health services, organisations and policy).

Process Mechanisms

The final element of the model are the 'Process Mechanisms'. These are the factors that have influenced the process and the challenges encountered in trying to work in more co-produced ways. In the case of STRENCO project, collaboration, recognition, dialogue, listening, shared power, decision making, equality, flexibility, facilitation, reciprocity, peer support, ownership, accomplishment,

innovation, motivation and culture change were identified as fundamental to the process of working in a co-produced approached.

The findings from STRENCO co-production process aligns with that of Cahn's four core values, in that people are recognised as assets, their involvement in no longer taken for granted, and there is reciprocity and investment in social capital (Cahn, 2008: 31) All stakeholders were valued as equal contributors, who shared power and contributed in the decision-making process (Rose & Kalathil, 2019). They worked in both formal and informal ways, listening and respecting each other. Reciprocity remained a key determinant throughout co-production (Boyle, Slay, and Stephens, 2010), in that participants mutually exchanged knowledge and experiences. This then led to peer support and social learning. The role of IP weeks activities facilitators was intrinsic to stimulating engagement and dialogue. Using problem based learning, the facilitators were chosen based on the purpose of sessions. They brough in different expertise, for example maaklab experts led the gamifications activities, or mental health lecturers facilitated the training days. As facilitators focus on the learning environment of the community, they requires a good knowledge and communication skill to meaningfully interact with members of the community (Wenger et al., 2002). A degree of flexibility was required throughout the IP weeks and project to allow space for unforeseen situations.

Recognition of people who use the services and harnessing the power of their networks was identified as an intermediate level of co-production by Needham & Carr's (2008). In the context of STRENCO, this was extended to the variety of healthcare systems, policy and competencies, this way reflecting the tripartite collaboration between countries and national contexts. As a part of the process, participants took ownership and accountability of tasks contributing to the development of resources (shared repertoire), which can lead to a greater sense of accomplishment.

In mental health, the co-production process is focused on achieving parity and equality amongst participants, through sharing power, norms, roles and relationships (NDTi, 2016). As such, CoPs provided a vehicle for regular engagement and for the continuity of mutual relationships. Adopting novel learning approaches, is also seen as a manner to encourage cross fertilisation of ideas between stakeholders. This integration of participants provided for more egalitarian interaction amongst participants as gamification and simulation encouraged motivation and more active participation, here boundaries dissolved and no consideration was given to medicalised identities.

Another positive aspect of the STENCO communities of practice is that participants negotiated a 'common ground' and yielded their identities in an attempt to create the correct condition for co-production to work, therefore mitigating the risks of institutional rules, roles and cultural norms expected to be followed (NDTi, 2016)

STRENCO project partners have adopted an informal educational strategy to facilitate social learning. The notion of situated learning within a community of practice is important when service users, carers, clinicians and the university, as partners facilitate creation of knowledge and seek ways of working. As learning is linked to participation in the community of practice, participants learn through trust, relationships they form and shared repertoire (Lave & Wenger, 2002). All of these elements were visible within the STRENCO project. Participants in STRENCO IP weeks and national CoPs brought personal knowledge and experiences related to mental health, which was then extended through participation in STRENCO. Participants reported self-awareness (‘*learned to relax’, to appreciate other people’s views’, ‘I feel could really change the way I would work)*, an important aspect of personal development, co-production and recovery journeys. This might have been triggered by the reflections embedded within the IP weeks and negotiation of own/community identity.

Challenges

Working in an international context to co-produce mental health competencies posed challenges. From the perspective of project managers/academics, financial implications, time commitment and distance/remote working remain one of the most difficult aspects. Remuneration of service users and carers constituted a significant challenge.

Another potential barrier was the time-consuming nature of co-production that requires active engagement, coordinating, planning and delivery of project, IP weeks and continuity of CoPs. Furthermore, participatory research requires trust and capacity building, which requires more time from stakeholders. Distance working between institutions added an extra layer of complexity. COVID_19 had significant implication on academics’ workload, which then impacted on their availability to participate in the project. Shorter online meetings and ongoing discussion via Slack/emails enabled academics to meaningfully contribute and progress.

A significant limitation in the project was creating mechanisms for the higher levels of involvement and integration of service users and family members in projects such as STRENCO. From the very first meeting the most notable absence was that of the service user (SU) voice in the application process, which then translated into plans for implementing the project. The nature of the project call and the funding model in this regard proved a limitation. The provision of tight financial parameters and categories for the inclusion of all stakeholders as a part of the process proved a challenge, requiring the utilisation of creative measures to solve the problems.

For students, the language barrier was the most challenging aspect, as some felt apprehensive communicating in English, yet through co-production their confidence increased, and one participant even reported an increase in language proficiency.

Additional support for service users involved in the IP weeks should be factored into project planning.

The introduction of GDPR /Data Protection Act (2018) had implications for institutions storage of project related data/documentation had to be effectively managed to ensure integrity, confidentiality and availability.

It should be highlighted that the STRENCO Model for working has needed to take into account a geographic base that spans the four corners of Europe. It comes from a diverse base of mental health care, with different systems of care, each in different states of change. Yet, despite these diverse variables and elements evidenced in previous research, such as competing priorities, goals and interdisciplinary conflict between the stakeholders in co-production, in the case of STRENCO, trust and good working relationships among partners helped to overcome the distances and challenges. All of those involved in the STRENCO Project entered with a common purpose, to strengthen competencies in mental health, it became a goal which all stakeholders ultimately shared.

Conclusion and Recommendations

The STRENCO Logic Model, a Tripartite Model for working in mental health is the outcome of an iterative process aligned with a participatory action research approach. It joined theory with practice, in the development of a guide for working in co-produced ways with service users, family members, carers, experts by experience, clinicians, academics and students, to strengthen competencies for working in mental health. The development of the model encompassed research evidence, project materials, data from meetings, minutes, reflections and project reports from the inception to the conclusion of the project. The principles of Communities of Practice influenced not only the development of national CoPs, but the whole STRENCO project, which acted as to act as a community of practice in itself that facilitated the creation of knowledge and sought new ways of working. It strengthened working relationships and stimulated active participations and sustained engagement.

Guided by the knowledge, understanding and experiences developed over the course of the STRENCO project, we recommend the following:

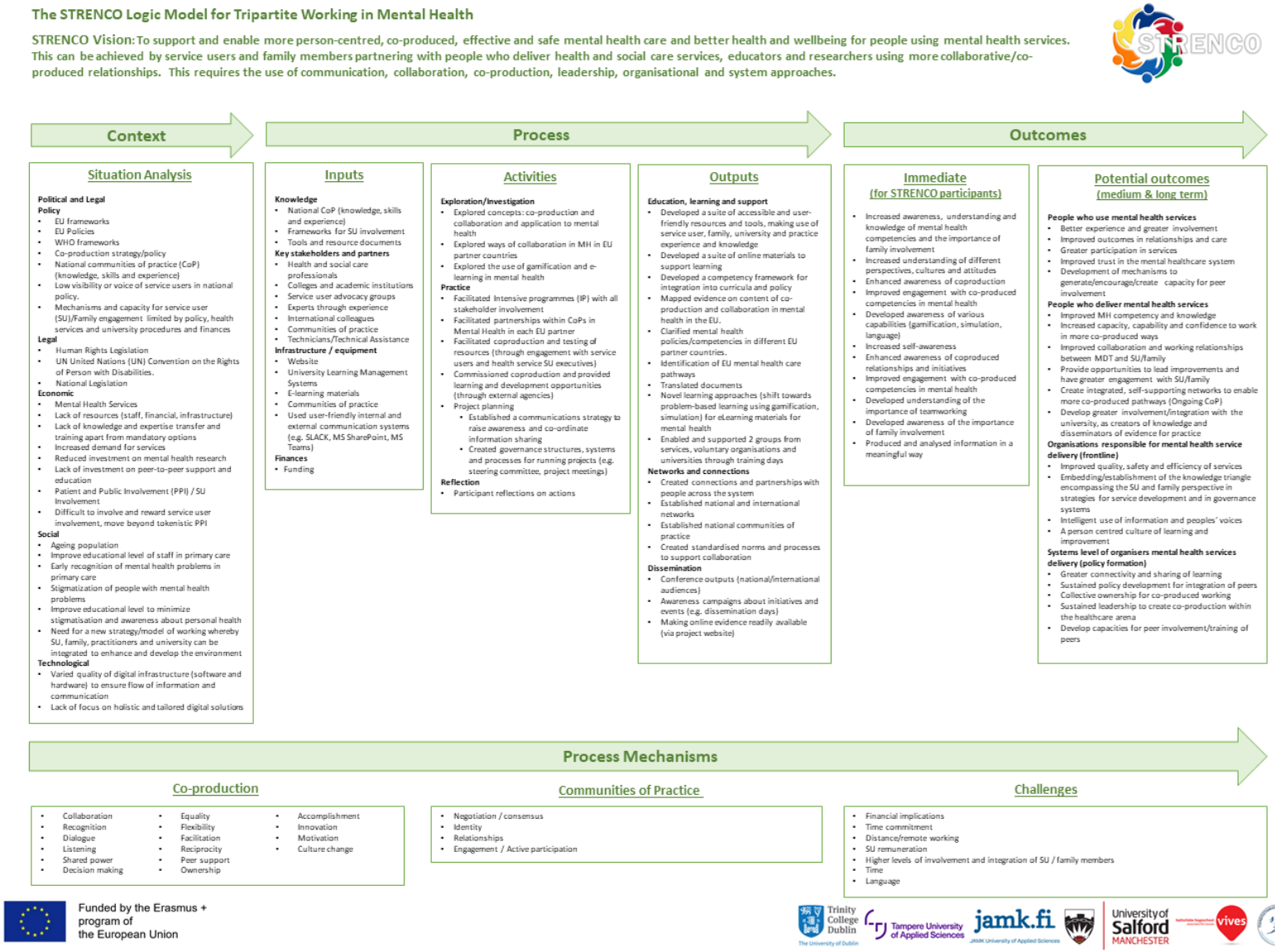
- The application of this model to guide, plan, implement and evaluate co-production and to support and enable more person-centred, co-produced, effective and safe mental health care and better health and wellbeing for people using mental health services.
- Examine the context in which the project is developed (situational analysis) to determine potential constrains and pitfalls.
- Use of Communities of Practice, as means of situated learning, regular engagement and the continuity of mutual relationships.

- Adopt a participatory approach to inform the development of logic models in their applicability and relevance.
- Act with caution about the possibility of challenges of working in a co-produced way, including funding, well-being, renumeration of service users and carers, time commitment and other unforeseen events (e.g. COVID_19).
- Choose appropriate digital technologies to maintain ongoing communication and collaboration and remove distance/remote working barriers.
- Include capacity within project budgets whereby the tight financial parameters and categories for the inclusion of all stakeholders are addressed to ensure that SU are involved throughput the process (commencing with the application process).
- For projects, which require translation include higher budgets for translations

Acknowledgement

We would like to thank Erasmus+ for funding this project. We are grateful for the continuous support and expertise given by service users, students, healthcare professionals and all members of national communities of practice. In particular, we would like to thank Dr Gary Lamph for his contribution during the initial stages of the project.

Appendix 1


The STRENCO Logic Model for Tripartite Working in Mental Health
STRENCO Vision: To support and enable more person-centred, co-produced, effective and safe mental health care and better health and wellbeing for people using mental health services. This can be achieved by service users and family members partnering with people who deliver health and social care services, educators and researchers using more collaborative/co-produced relationships. This requires the use of communication, collaboration, co-production, leadership, organisational and system approaches.
STRENCO
Context
Process
Outcomes
Situation Analysis
Political and Legal
Policy
EU frameworks
EU Policies
WHO frameworks
Co-production strategy/policy
National communities of practice (CoP) (knowledge, skills and experience)
Low visibility or voice of service users in national policy.
Mechanisms and capacity for service user (SU)/Family engagement limited by policy, health services and university procedures and finances
Legal
Human Rights Legislation
UN United Nations (UN) Convention on the Rights of Person with Disabilities.
National Legislation
Economic
Mental Health Services
Lack of resources (staff, financial, infrastructure)
Lack of knowledge and expertise transfer and training apart from mandatory options
Increased demand for services
Reduced investment on mental health research
Lack of investment on peer-to-peer support and education
Patient and Public Involvement (PPI) / SU Involvement
Difficult to involve and reward service user involvement, move beyond tokenistic PPI
Social
Ageing population
Improve educational level of staff in primary care
Early recognition of mental health problems in primary care
Stigmatization of people with mental health problems
Improve educational level to minimize stigmatisation and awareness about personal health
Need for a new strategy/model of working whereby SU, family, practitioners and university can be integrated to enhance and develop the environment
Technological
Varied quality of digital infrastructure (software and hardware) to ensure flow of information and communication
Lack of focus on holistic and tailored digital solutions
Inputs
Knowledge
National CoP (knowledge, skills and experience)
Frameworks for SU involvement
Tools and resource documents
Key stakeholders and partners
Health and social care professionals
Colleges and academic institutions
Service user advocacy groups
Experts through experience
International colleagues
Communities of practice
Technicians/Technical Assistance
Infrastructure / equipment
Website
University Learning Management Systems
E-learning materials
Communities of practice
Used user-friendly internal and external communication systems (e.g. SLACK, MS SharePoint, MS Teams)
Finances
Funding
Activities
Exploration/Investigation
Explored concepts: co-production and collaboration and application to mental health
Explored ways of collaboration in MH in EU partner countries
Explored the use of gamification and e-learning in mental health
Practice
Facilitated Intensive programmes (IP) with all stakeholder involvement
Facilitated partnerships within CoPs in Mental Health in each EU partner
Facilitated coproduction and testing of resources (through engagement with service users and health service SU executives)
Commissioned coproduction and provided learning and development opportunities (through external agencies)
Project planning
Established a communications strategy to raise awareness and co-ordinate information sharing
Created governance structures, systems and processes for running projects (e.g. steering committee, project meetings)
Reflection
Participant reflections on actions
Outputs
Education, learning and support
Developed a suite of accessible and user-friendly resources and tools, making use of service user, family, university and practice experience and knowledge
Developed a suite of online materials to support learning
Developed a competency framework for integration into curricula and policy
Mapped evidence on content of co-production and collaboration in mental health in the EU.
Clarified mental health policies/competencies in different EU partner countries.
Identification of EU mental health care pathways
Translated documents
Novel learning approaches (shift towards problem-based learning using gamification, simulation) for eLearning materials for mental health
Enabled and supported 2 groups from services, voluntary organisations and universities through training days
Networks and connections
Created connections and partnerships with people across the system
Established national and international networks
Established national communities of practice
Created standardised norms and processes to support collaboration
Dissemination
Conference outputs (national/international audiences)
Awareness campaigns about initiatives and events (e.g. dissemination days)
Making online evidence readily available (via project website)
Immediate (for STRENCO participants)
Increased awareness, understanding and knowledge of mental health competencies and the importance of family involvement
Increased understanding of different perspectives, cultures and attitudes
Enhanced awareness of coproduction
Improved engagement with co-produced competencies in mental health
Developed awareness of various capabilities (gamification, simulation, language)
Increased self-awareness
Enhanced awareness of coproduced relationships and initiatives
Improved engagement with co-produced competencies in mental health
Developed understanding of the importance of teamworking
Developed awareness of the importance of family involvement
Produced and analysed information in a meaningful way
Potential outcomes (medium & long term)
People who use mental health services
Better experience and greater involvement
Improved outcomes in relationships and care
Greater participation in services
Improved trust in the mental healthcare system
Development of mechanisms to generate/encourage/create capacity for peer involvement
People who deliver mental health services
Improved MH competency and knowledge
Increased capacity, capability and confidence to work in more co-produced ways
Improved collaboration and working relationships between MDT and SU/family
Provide opportunities to lead improvements and have greater engagement with SU/family
Create integrated, self-supporting networks to enable more co-produced pathways (Ongoing CoP)
Develop greater involvement/integration with the university, as creators of knowledge and disseminators of evidence for practice
Organisations responsible for mental health service delivery (frontline)
Improved quality, safety and efficiency of services
Embedding/establishment of the knowledge triangle encompassing the SU and family perspective in strategies for service development and in governance systems
Intelligent use of information and peoples' voices
A person centred culture of learning and improvement
Systems level of organisers mental health services delivery (policy formation)
Greater connectivity and sharing of learning
Sustained policy development for integration of peers
Collective ownership for co-produced working
Sustained leadership to create co-production within the healthcare arena
Develop capacities for peer involvement/training of peers
Process Mechanisms
Co-production
Collaboration
Recognition
Dialogue
Listening
Shared power
Decision making
Equality
Flexibility
Facilitation
Reciprocity
Peer support
Ownership
Accomplishment
Innovation
Motivation
Culture change
Communities of Practice
Negotiation / consensus
Identity
Relationships
Engagement / Active participation
Challenges
Financial implications
Time commitment
Distance/remote working
SU remuneration
Higher levels of involvement and integration of SU / family members
Time
Language
Funded by the Erasmus + program of the European Union

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Funded by the Erasmus + program of the European Union

The STRENCO Logic Model for tripartite working in mental health (inc. supporting data)

Output 3

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ISBN: 9781912337422

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Glossary of Terms

CoP	Community of Practice
EU	European Union
ECTS	European Credit Transfer System
GDP	Gross Domestic Product
GDPR	General Data Protection Regulation
HSE	Health Service Executive
IP	Intensive Programmes The Intensive Programmes were underpinned with an educational philosophy of education by doing with gamification principles embedded, to increase motivation and active participation amongst stakeholders.
MDOTs	Mentally Disordered Offender Teams
MH	Mental Health
MHC	Mental Health Care
MS	Microsoft
NGO	Non-Government Organisation
NHS	National Health Service
PDR	Participatory Design Research
PEST	Political and Legal, Economic, Social and Cultural, and Technological
PESTLE	Political, Economic, Sociological, Technological, Legal and Environment
PPI	Public and Patient Involvement
SU	Service Users
TCD	Trinity Collage Dublin
UN	United Nations
UoS	University of Salford
WHO	World Health Organization
VR	Virtual Reality

Introduction

This report presents the STRENCO Logic Model, a Tripartite Model for working in mental health in a more co-produced way (Figure 1, page 28). It represents the product of Output 3 in the STRENCO Project that seeks to strengthen competencies for working in mental health. Working in more co-produced ways is aspired to for mental health care with a greater inclusiveness of service users, family members, carers, experts by experience, clinicians, academics and students in relation to decision making processes, care, policy and research. The development of the model was conceived in the context of EU policy emphasising the role of research, education and practice as co-creators in developing new approaches for working.

Working in more co-produced ways can present challenges to all people involved in mental health care. Even within this project we have seen how in the language itself, that there are differing interpretations in meanings and across cultures. Different countries are at different stages in the move to shift perspectives and policies in mental health care. Whilst many people talk about changes in working in more co-produced ways, few examples of how this can be done by involving all dimension in the knowledge triangle currently exist. It is to this end that output 3 seeks to address a way of working whereby this can be done. In making the proposal to create a Tripartite Model for working, the partners agreed and put forward a method where all stakeholders in the mental health conversation could be involved in the co-creation of knowledge and learning that might strengthen and improve competencies in mental health. An approach, drawing from the principles of participatory action research was adopted. This approach proposed the development of Communities of Practice (CoPs) comprising service users, family members, carers, experts by experience, clinicians, academics and students in each of the six partner institutions in the five countries. These CoPs fed into the central project as 'think tanks', both for the development of the Outputs on the project and for the running of the associated Intensive Programmes for students and teachers. Through our learning in these Communities of Practice, they have become the keystone of the STRENCO Logic Model and as a way of working.

STRENCO Vision was to support and enable a more person-centred, co-produced, effective and safe mental health care and better health and wellbeing for people using mental health services. It is underpinned by the belief that this can be achieved through service users and family members partnering with people who deliver health and social care services, educators, researchers and students using more collaborative/co-produced relationships. This requires the use of communication, collaboration, co-production, leadership, organisational and system approaches. These are the foundational principles that we have endeavoured to work by, over the course of the project.

The purpose of the STRENCO Logic Model is to provide mechanisms through which co-produced working can be facilitated, to include service users, carers, clinicians and the university, as partners in

the creation of knowledge and ways of working. The STRENCO Logic Model is built through learning by experience, as the entire project has been an exercise in finding ways of more co-produced working. The data that informs the development of the model, is drawn from research evidence, project materials, meetings minutes, reflections and project reports from the inception to the conclusion of the project. It has evaluated what has worked and what has not worked.

As a Logic Model, it is structured across the domains of context, process and outcomes. It begins with a situation analysis of the context for mental health in which the STENCO project was developed. This was done using PEST analysis. The analysis identifies the discussions in and around the areas of literature, experiences and policy at both national and international levels.

The process element of the model explores inputs or resources, which can be utilised in developing more co-produced ways of working. These identify the use of national and international policies and frameworks, key stakeholders for involvement, infrastructural elements and importantly the resources required for development of these approaches.

Process also includes activities or things that were/can be accomplished within the realm of co-produced working. These are represented in the concepts of investigation, practice and reflection. The final element of process are outputs. Outputs represent the results of activity. In this regard, the model identifies the importance of education, learning and support, making connections and establishing networks, and formats for the dissemination of information, as key components in the model's outputs.

The third element of the model are the outcomes, reported as immediate and long-term.

The final element of the model are the process mechanisms. These are the factors that have influenced the process and the challenges encountered in trying to work in more co-produced ways. They relate to the processes of co-production, the Community of Practice and the challenges that need to be overcome in working in more co-produced ways in the international context.

Presented in the output report here is the development and validation of the model using the analysis of learning acquired over the course of the STRENCO Project. This has been extrapolated from the data gathered over the course of the project using framework analysis and transposed to higher order concepts for the formation of the final Logic Model. Each individual stage of the model is explored through the data, and the implications of the higher order concepts generated, considered in the discussion.

STRENCO context and setting

Mental health is 'the foundation for happy, fulfilled, productive lives' (OECD/EU 2018: 20) and plays a significant role in all stages of everyday life, from childhood and adolescence through adulthood. The importance of mental health is increasingly recognized as part of health and wellbeing. Nevertheless, mental health problems remain a challenging phenomenon given the widespread and disability burden associated with them (Vigo, Thornicroft & Atun, 2016). Over the past 10 years mental illness has been identified as a global problem and has attracted increased attention from educators and policy developers (Balon et al., 2016).

In 2009, the World Health Organisation (WHO 2009:1) stated that 'for too long, mental disorders have been largely overlooked by health systems' despite being present across the globe. This was due to lack of political support, inadequate management, overburdened health services and, at times, resistance from policymakers and health workers. Limited change has continued and the lack of high-quality mental health care and services across the world remains due to staff shortages, research, policy changes, and stigma, all of which contribute to the gaps in treatment (Joshi, 2018).

Despite increased expenditure on mental health by higher income countries (for example, European countries) compared to lower income countries, the proportion of the healthcare budget focussed on mental health remains low compared to physical health. Low and middle-income countries account for 80 % of the global population, yet they invest less than 20 % on mental health resources (Patel, Minas, Cohen & Prince, 2013).

Reduced expenditure impacts on the quality and amount of resources available to population and highlights a need to adapt and diversify the way services are developed and implemented to ensure that they are fit for purpose and of high quality. Co-production between service users, carers and healthcare professionals may go some way to ensure that services are suitable and meet the needs of service users and carers. One method to construct co-produced environments is through Wenger's community of practice framework that facilitates knowledge construction (Wenger, 1998).

The WHO European Mental Health Action Plan (2013) prioritised the rights and empowerment of service users and their families. Service user partnership and involvement in education and service delivery is growing in importance in the development of future and current practices. Despite policies placing a strong emphasis on positive approaches, like recovery-orientated practices and social inclusion, service user empowerment and involvement is still a common challenge across European Union countries. Higher Education Institutions have a significant role to play in changing this, by developing the competencies needed by current and future practitioners. Across Europe, currently there is no model in mental health that harnesses the contributions service users and their families have to make.

Following a successful application, a consortium of 6 partner universities from 5 different European countries [Trinity College Dublin (Ireland), The University of Salford (UK), Tampere University of Applied Sciences (Finland), VIVES University of Applied Sciences (Belgium), Jyväskylä University of Applied Sciences (Finland) and University of West Attica (Greece)] was funded under the Erasmus+ EU project (STRENCO) joined together, to promote the area of collaborative working in mental health. The project was funded for 3 years with the aim of strengthening multi-professional competencies, in mental health in an international context through co-production with academics, students, service users and professionals.

The aims of the project were to:

- *Output 1: Create open-source eLearning materials in a coproduced manner*
- *Output 2: Develop assessment tools that assess the competency for collaborative mental health working in an international context*
- *Output 3: Develop a Tripartite Model for working collaboratively between education, research and practice that encompasses service user involvement*

The STRENCO project followed the principles of Participatory Design Research [PDR] approach, (Gregory, 2003, Spinuzzi, 2005; Lundin et al., 2013). In this project all the participants, students, service users, practitioners and academics contributed to co-produce resources and knowledge in mental health. The principles of co-production (Slay & Stephens, 2013) and communities of practice (CoP) approaches (Wenger, 1998) were adopted to enable knowledge transfer between participants and strengthen the skills for international collaboration between partners, as well as collaboration between future and current professionals with service users and family members/carers in an international context.

The project consisted of two Intensive Programme IP and six transnational project meetings. A third Intensive Programme was planned to occur in Finland in 2020, however due to the COVID-19 pandemic, this could not proceed. These events were supplemented with 22 formal online project meetings, and national CoP meetings at the partner sites and numerous informal online meetings to discuss particular aspects of the project development.

Situation analysis: political, legal, economic, socio-cultural and technological spheres in mental health

Context is a source of information to understand and evaluate the challenges and opportunities available in a given area. As a way of understanding the context underpinning the development of the STRENCO Tripartite Logic Model, a situation analysis of the prevailing discussions in mental health across Europe was undertaken. As identified by WHO (2001), social, political and economic realities must be recognised at local, regional and national levels.

Situation analysis is the process of critically evaluating the internal and external factors that affect a new policy, strategy or initiative (Rajan, 2016). It can be used to assess "a current health sector situation […] including cause and effect and provide an evidence-informed basis for responding to health sector needs and expectations of the population […] (and) provide an evidence-informed basis for formulating future strategic directions for the health sector" (Rajan, 2016: 1). The approach used in this analysis was PEST, a variant of PESTLE analysis (Rastogi & Trivedi, 2016). PEST explores the Political and legal (P), Economic (E), Social and cultural (S), and technological (T) aspects of a situation. PEST analysis tools are useful to explore the changes and effects in a macro environment (Sammut-Bonnici & Galea, 2015) and have been previously used in mental healthcare (Kożybska & Karakiewicz, 2016).

PEST explores multiple factors, such as practical experiences at national levels, challenges seen in the relationships between stakeholders, critiques of existing policy and evidence from research. The PEST analysis presented here (Table 1) is based on evidence reported in the literature and analysis of national policies and developments in mental health within the project, by the university partners. The areas identified are presented under each category of the analysis.

Table 1 Summary of PEST analysis for STRENCO

P	E	S	T
<u>Policy</u> ▪ EU frameworks ▪ EU Policies ▪ WHO frameworks <u>Co-production strategy/policy</u> ▪ National CoP (knowledge, skills and experience) ▪ Low visibility or voice of service users in national policy.	<u>Mental Health Services</u> ▪ Lack of resources (staff, financial, infrastructure) ▪ Lack of knowledge and expertise transfer and training apart from mandatory options ▪ Increased demand for services	▪ Ageing population ▪ Improve educational level of staff in primary care ▪ Early recognition of mental health problems in primary care ▪ Stigmatization of people with mental health	▪ Varied quality of digital infrastructure (software and hardware) to ensure flow of information and communication ▪ Digital wellbeing ▪ Lack of focus on holistic and tailored digital solutions

▪ Mechanisms and capacity for Service Users (SU)/Family engagement limited by policy, health services and university procedures and finances	▪ Reduced investment on mental health research ▪ Lack of investment on peer-to-peer support and education <u>Patient and Public Involvement (PPI)/SU involvement</u> ▪ Difficult to involve and reward service user involvement, move beyond tokenistic PPI	▪ Improve educational level to minimize stigmatisation and awareness about personal health ▪ Need for a new strategy/model of working whereby SU, family, practitioners and university can be integrated to enhance and develop the environment	

Political and Legal Policy

International policy

The importance of mental health is increasingly recognized. The WHO Mental Health Action Plan 2013-2020 (WHO, 2013) identified major objectives to be achieved within the mental health landscape. The plan identified the needs for more effective leadership and governance for mental health, and calls for the provision of comprehensive, integrated mental health and social care services in community-based settings. It also prioritises the implementation of strategies for mental health promotion and the prevention of mental health problems. These priorities have been carried across into the United Nations 2030 Agenda for substantiable development, where the centrality of mental health as a global priority is once again articulated with a goal 'to promote mental health and well-being' (United Nations, 2015 :7) in its identification of Sustainable Development Goals (SDG), United Nations aspires to moving mental health from society's margins to the centre of health, with a priority for the development of a global agenda in relation to the promotion of mental health and well-being. The WHO (2017) strategy prioritises the need to find a 'wise' balance in mental health care that is based on values and evidence. At the same time, the WHO urges states to invest more in mental healthcare than is currently provided; highlighting the considerable variance in the percentage of health budgets allocated to mental health across the continent; varying from highs of 12% (UK) to lower levels of 7% in Ireland and 6% in Belgium.

Multiple factors influence the development and implementation of policy at international, national, and local levels are presented in Table 2.

Table 2 Factors impacting on mental health policy

Health of the wider economy
Emphasis placed by a government on primary /public mental health care
Securitisation in mental health services and the level of risk aversion that permeate the wider context
Decisions surrounding priorities (e.g. early detection and early intervention)
Responses to media reporting & public anxiety surrounding mental health and failures in care delivery (e.g. high-profile cases)
Responses to media reporting & public anxiety surrounding mental health and failures in care delivery (e.g. high-profile cases)
Prevalence of mental illness and rates of suicide within the country
Degree of transition countries have achieved in the process of de-institutionalisation
Movement towards consumerism in mental health care and the growth of the service user movement
Need for greater expenditure on mental health education & promotion
Influence of pharmaceutical industry

In 'Mental Health: New Understanding New Hope' (WHO, 2001), the WHO amongst its 10 key recommendations, identifies the need to provide care and treatment in primary care, to educate the public in relation to mental health and stigma, and to involve communities, families and consumers *'*in the development and decision-making of policies, programmes and services' (WHO, 2001: 111). The implementation of the World Health Organization Action Plan (2013) recommendations on the development of community mental healthcare models of care is at differing places across Europe; many countries are still in transition from institutional care to a community model, with the medical model still influencing care in the majority of countries across Europe. Puras (2018) the UN special rapporteur on mental health considers that all stakeholders in mental health should rethink their models of care, especially the classical biomedical paradigm, of 'patients' diagnosed with diseases and 'professionals' empowered with solutions which has led to an asymmetry of power that is more pronounced within mental health in comparison to the rest of medicine. This approach is in conflict with a human rights framework, which sees the person as a subject and owner of rights with a necessity for informed consent. In addition, Puras (2018) considers that the biomedical model has not kept its promise to reduce stigma, discrimination and exclusion and considers that the overuse of non-consensual measures and biomedical

model interventions in a decision-making process dominated by the medical profession being part contributor to exclusion. In countries such as Ireland and the UK, the evolving policy position seeks to ensure that users are involved in the design, implementation, delivery and evaluation of mental health services, systems, and policies. To ensure the wider adoption of community-oriented care, there is a need to redirect investment from institutional care, to community-based services and to invest more in psychosocial services that are integrated into primary care and community services that empower users and respect their autonomy (Puras, 2018).

EU policies and frameworks propose the use of the knowledge triangle, as a strategic tool for change and the integration of research evidence and innovation into everyday practice (EU 2009/C 302/03). The knowledge triangle *'*relates to the need for improving the impact of investments in the three forms of activity – education, research and innovation – by systemic and continuous interaction*'* (EU 2009/C 302/03). It is a key element in the European innovation, research and education policy landscape (Technpolis, 2012). The approach sees the university no longer as the sole area for the generation of new knowledge, rather the three elements of the triangle, (higher) education, research, and practice (business) operating in harmony. However, whilst healthcare professionals are conscious of the need for ongoing professional development and the incorporation of evidence-based practice, there is limited understanding of the knowledge triangle approach and its application for practice. In many countries, policy shows the alignment of universities to health care providers for the training of healthcare professionals, however mechanisms and opportunities for engagement outside of undergraduate training are limited, with health service links with universities for practice development largely underutilised or untapped. This limits clinician's ability to enact developments in mental health care.

UK Policy

In the UK, several mental health policy documents have been published over the past two decades with the aim to improve mental health services for people within England. In 1999, the National Service Framework for Mental Health was launched to establish a comprehensive evidence-based service. This was followed by the NHS Plan in 2000 which set targets and provide funding to make the Framework a reality. A National Service Framework for Children, Young People and Maternity Services was then launched in 2004.

In 2011, the Coalition government published a mental health strategy setting out six objectives, including improvement in the outcomes, of physical health and experience of care of people with mental health problems, and a reduction in avoidable harm and stigma. NHS England and the Department of Health published The Five Year Forward View (2014) and Future in Mind (2015). However, despite these initiatives, challenges with system wide implementation coupled with an increase in people using

mental health services has led to inadequate provision and worsening outcomes in recent years, including a rise in the number of people taking their own lives (The Mental Health Taskforce, 2016).

More recently, The Modernisation of the Mental Health Act (2018) report and the NHS Long Term Plan (2019), has set out the redesign of how care will be delivered and future proofed. The Independent Review of the Mental Health Act 1983 (2018) set out recommendations for the government on how the Act can change practices, highlighting that co-production should be used in developing future independent reports.

Belgium Policy

The landscape of Belgian mental health care has undergone a profound evolution in the last decades, recognised as 'article 107' (Belgian Federal Government, 2011). Before 2012, the mental health care landscape was characterized by a dominant residential offer in which Belgium had the second highest number of beds per 100,000 inhabitants. The rest of the care supply was very fragmented and a confusing picture of separate projects and organisations. Also, in the field of mental health prevention, the supply was rather limited, the funding of mental health care was also a complex issue due to different governments. Nevertheless, there is a strong increase of people with mental health problems which also translates into high suicide rates.

In 2012, the reform of mental health care started and one of the main features was the transformation of residential beds into community-based care or mobile psychiatric teams. In addition, there also is the reorganization of the MHC landscape into regional care networks, which have to further manage the local MHC offer. These networks should roll out and manage five functions in their region. This new model is based on a balanced care model and within these five functions, there is a strong focus on recovery, patient and family participation. This reform has started in 2012 and continues to be rolled out and refined.

Finland Policy

Finland is in the middle of a health and social services reform, with the purpose to address issues in all health care, social services and mental health and substance abuse services. Changes are likely to incorporate adaptations to the financial model and a change of service providers. This reform has been ongoing for several years and continues to evolve. Finnish health care and social services current provision differs from many countries and can be described as a municipality-based system in which primary health care services are located in each of municipalities, which comprise together the university hospital districts. Mental health and substance abuse services are located both in the primary level and in the hospital districts; there is no one national service provision model. Non-Government Organisations (NGOs), so called third sector, have an important role besides public services, especially

in informal support provision for people in different age groups, in other peer -support provision and increasingly digital support services, like online chats, call centers etc. For example, the world's oldest voluntary mental health organization is in Finland was established in1897. Private sector has a smaller role when comparing to public services, albeit psychotherapy services being provided by private psychotherapists or private psychotherapy centers.

During the recent years the 'National Plan for Mental Health and Substance Abuse Work - Proposals for development of mental health and substance abuse work 2015' has guided the development of mental health and substance abuse service provision (Ministry of Social affairs and Health, 2015). In 2020, the new Mental Health Strategy was launched (Finland Ministry of Social Affairs and Health, 2020), which will guide the actions until 2030, so it is a long-term strategy. For the first implementation years the aims are to develop services, to launch a suicide prevention program and to increase mental health skills in people's everyday environments. The latter is seen as a part of a wider promotion of well-being and health. Five priority areas cover several items, many of those promoting social inclusion for all. Prior to the launch of the Mental Health Strategy, social inclusion, possibilities of participation and involvement formed a strong focus area in Finnish health care and social policy discussions. In Finland, this development has been supported and strengthen with several national and local projects and activities for example National Institute of Health and Welfare have supported these actions strongly and promotion materials have been launched for everyone's use. The emphasis on these issues is seen as an important part of Human Rights to enhance and promote wellbeing of all, and especially to prevent social exclusion of those in risk of marginalization. Different activities to increase the participation of the persons with lived experiences in different service settings as well as in education and research could be seen as a part of this development.

Greece Policy

Traditionally, psychiatric care in Greece was institutionalised but since 1983, the Psychiatric Reform commenced through the passing of the National Health System Act 2071/83 (Ministry of Health and Welfare, 2001). The most important milestone for this reform was deinstitutionalization of mental health care and the development of community-based services under the programme called "Psychargos" which has been implemented in phases (Economou et al., 2017). In 2011, the "Psychargos III" started with the aim to continue strengthening mental health care reforms and it is based on three pillars (Ministry of Health and Social Solidarity, 2011):

1. actions to develop further the community mental health settings in order to cover all the mental health needs at the sectorial level,

2. actions for the promotion of mental health among the general population and the prevention ill mental health,
3. actions to organize the psychiatric care system (sectoral allocation of services, monitoring, evaluation, research activities and staff training activities).

In March 2017, a new law, provided the establishment of a number of scientific and administrative committees, councils at both regional and sectoral levels and coordination bodies in order to achieve better coordination of mental health services, greater participation of citizens in mental health policy decision-making, and the protection of the rights of the users of mental health services (Economou et al., 2017).

Ireland Policy

The mental health system in Ireland has its origins in the asylum system of care that began in 1812 when Ireland was a part of the United Kingdom. The model of care provided 'new and an improved system of treatment' (Prior, 2012) largely characterised by incarceration, which remained in place until the 1980s. Following the independence of Ireland in 1949, the system remained in place and at its peak in the 1950s, almost 20,000 people received treatment in these asylums. This figure had fallen dramatically by the end of the 1980s following the implementation of 'Planning for the Future' in 1984, that proposed a community-based model of mental health care, the principles of which still form a cornerstone of current policy. The asylum system was supported by legislation, introduced as the Mental Treatment Act (MTA, 1945). This act governed all aspects of mental health care from detention as involuntary patients, to employment provisions for staff. Despite several attempts to replace the Act, it remained in place until 2001.

Mental health care in Ireland is currently governed by the Mental Health Act (2001). The provisions of the Act were fully implemented in 2006. It was a radical overhaul of mental health care which for the first time brought representation of service users into the domain of the regulation of Mental Health care. The Act established an independent Mental Health Commission, introduced Mental Health Tribunals to review involuntary admissions and treatment orders thereby establishing collaboration between service users and legal system through appointed solicitors. Subsequent amendments to the Mental Health Act in 2008 & 2015.

In succeeding years, the landscape of mental health changed significantly. The Irish Advocacy Network which had been formed in 1999, as a service user-led organisation working independently and in partnership with mental health services was sanctioned by Minister for Health and Children in 2002. In 2004, the Health Service Executive (HSE) a national entity for the administration of healthcare was introduced. The Executive now has responsibility for all national mental health services.

In 2006, the Government of Ireland set out the direction of Mental Health Services in "A Vision for Change" (2006). This document proposed a radical overhaul of the approach to mental health care, advocating greater consultation and involvement of service users in services, changes to legislation and the adoption of a recovery model, as the fundamental approach to care. 2006 also saw Ireland ratify the United Nations (UN) Convention on the Rights of Person with Disabilities in Ireland.

Subsequent years saw an increase in the number of initiatives with the opening of peer support and community housing project to support people with mental health problems. It also marked the publication of research by the Mental Health Commission to support the implementation of recovery-based approaches (2007, 2008) nationally. The enshrinement of recovery has progressed with the founding of Advancing Recovery in Ireland (ARI), as a National Mental Health Division initiative to bring together people who provide services, those who use them and their families and community support, to help make mental health services more recovery focused. In 2015, the HSE established the Office of Mental Health Engagement, the purpose of which is to support the development of mechanisms for service user and carer engagement. This policy saw the introduction of 9 HSE Area Leads for mental health engagement in 2017. These Area Leads, who were comprised of service users, carers and family members were tasked to represent the views of service users, family members and carers in mental health services. The role includes being a full and proactive member of the Area Management Team for Mental Health Services and participating effectively in all related processes. The period of 2017-18, saw the introduction of Peer Support

Workers directly employed by HSE and the establishment of HSE Area Fora. Peer support workers were individuals with self-experience of mental health difficulties, with a good level of recovery, were employed to offer support to service users across the country in a new approach by the HSE Mental Health Division. The purpose of the Area Fora, was to develop networks to work collaboratively for improved mental health services across the local regions in Ireland through gathering information from local forums and ensuring that this feedback goes to the MH Area Management Teams and where necessary the National Management Team for deliberation and consideration.

As a mental health care policy, 'A Vision for Change' (2006) was scheduled to be replaced in 2016. In 2017, an Oversight Group was established to provide a report to the Irish Department of Health setting out current and future service priorities. This report, Sharing the Vision was published 2020. At its heart are the principles of human rights, recovery, and trauma informed care, delivered with community-based care as a central tenet and greater involvement of peers' networks and recovery education.

Co-production strategy/policy

The analysis performed by the partners identifies that there is still low visibility for the voice of mental health service users in national policies, apart from Greece where the new law in 2017, emphasised involvement in mental health policy, decision-making, and services. (Economou et al., 2017). Furthermore, the analysis of the status of their countries in the adoption of more co-produced ways of working in mental health revealed mixed levels of adoption. Whilst in some countries co-production was written into national policy frameworks for example Ireland's Sharing the Vision (2020: 75), in others the integration of service users was characterised by involvement in research projects (Lamph et al., 2014; Castro et al., 2018; Lamph et al., 2018), with the integration of service users and family members into mental health service development, delivery, evaluation and research a work in progress. However, in these programmes, the principles of co-production were identified as offering a lot of possibility for improvements. Overall, in these instances the sustainability and spread of successful co-produced initiatives are limited. Many of the projects are research funded, and budgets for projects do not extend to wider implementation, outside of the original project. When funding is exhausted, the projects wither.

The partners analysis identified how mechanisms and capacity for SU/Family engagement with the universities is constrained by policy, health services involvement, and university procedures and finances. In most countries there are no clear policies for developing the peer advocacy role amongst SU/family members. There is ambiguity in what is meant by an 'experts by experience' role. The ambiguity is also seen to exist within all policy from EU level to local policy levels. There does not appear to be any clear understanding of which domain SU expertise and 'experts by experience' resides within the knowledge triangle proposed by (EU 2009/C 302/03). In addition, there are debates on whether experts by experience should be paid or provide services on a voluntary basis.

What was seen across the project partners was that there were varying degrees of SU/family engagement and involvement in mental healthcare environments and academic departments delivering health care education. Service user and voluntary organisation links with universities were limited with no clear strategy and the role of service user advocacy in services was not linked to the university.

Policies for developing a peer advocacy role amongst SU/family members is limited. There are no agreed standards, education, or training programmes to support experts by experience in their development. For example, in Finland many organizations have established their own ways of working and individualised policies related to service user involvement. Some universities and services do offer support and developmental programmes; however, these vary in duration and quality ranging from just 2 days to 8 months. Additionally, there is no regulation of this education.

Limitations on co-production are not confined to the service user domain, equally the number of staff with skills and expertise for working in co-produced ways is limited, identified in this regard is that

resources and training on co-produced relationships are not widely available and mandatory training programmes occupy the majority of training budgets. As seen with service user education, equally mental health education programs vary a lot across the participating coutries, whilst in clinical environments negative attitudes towards co-production quite often present an obstacle. This has led to the STRENCO project looking at ways in which a tripartite model of working can explore the development of more meaningful ways of working.

Economic

Starfield & Shi (2002) consider that the quality of mental health care is not related so much to policy, it is dependent on the structure, location and delivery of services. In this regard, they consider good health correlates with the equitable distribution of resources. Funding and resources allocated to mental health are related to multiple factors, these include the economic strength of a country, the prevailing political attitude to public spending and the relative priority given to different aspects of health (Nolan, 2014). The EU adopts a mixture of funding models for health care that lead to differing ways in how health care is funded in Europe, these vary from centralised taxation (Ireland/UK), compulsory employee healthcare insurance (Germany, The Netherlands, Belgium, Greece), voluntary healthcare insurance models (Ireland/Greece) and direct patient payments (Ireland, England, Czech Republic, Greece). In the context of discussions on mental health there are many competing areas and needs in modern Mental Health Services (Table 3). Decisions on where spending needs to be allocated, can lead to complex discussions on the areas that need to be prioritised with varying priorities dependent on the evolution and development to the underlying model of care.

Table 3 Examples of varying priorities in mental health funding

Primary Care and Public Mental Health
In-patient Psychiatric Care
Community Mental Health Services and Community Mental Health Teams, Crisis Teams, Home-based Treatment, Assertive Outreach
Forensic Services: Low, medium, high security, Court Diversion, prison In-reach, MDOTs
Specialist services: i.e. Dual Diagnosis, Early Intervention Psychosis, CAMHS, Substance Misuse, Liaison Psychiatry, Care of older People, Rehabilitation, Personality Disorder Service, Women's Services
Developing Service User led interventions and the accommodating the voice of the service user
Non-statutory services

Finance and Mental Health Services

In 2018, it was estimated that mental health problems affected more than 84 million people across the EU countries, with the total costs of mental health problems amounting to more than 4% of GDP, and equivalent to approximately €600 billion annually when the costs of health systems and social welfare programmes, employment and productivity losses are included (OECD/EU, 2018). There is an increasing demand for mental health services and "promoting mental health and improving access to treatment for people with poor mental health should be a priority" (OECD/EU, 2018: 3). Analysis of prevalence at a national level estimate Finland, the Netherlands, France and Ireland experience the highest rates in the 28 EU countries with more than 18.5% o of the population experiencing mental health problems. 'Excess mortality' is associated with mental ill-health, with in excess of 84,000 deaths related to mental health problems and suicide in EU countries in 2015. Decreased mortality rates are also associated with serious mental health problems with life expectancy decreases of between 10-20 years identified in research (OECD, 2014; Coldefy & Gandré, 2018; Gandré & Coldefy, 2020). Better engagement with service users can improve outcomes and reduce the overall costs of mental health care. Visser et al. (2012) estimate reductions of 20% in expenditure on acute health care can be achieved by increasing the integration of care and having greater involvement of people who use services in care decisions.

An increasing number of people are seeking help for mental health problems leading to greater demand for services and increased pressure on mental health services (Chan, 2008; MHC (Irl.), 2011, Stuckler et al., 2011). An issue which has been compounded by the COVID-19 crisis (WHO, 2020). Historically, mental health has been identified in many countries as a low priority for national policy makers (McDaid et al., 2008). This has resulted in a lack of resources (staff, financial, infrastructure). With low levels of recruitment for specialisation in mental health a common factor (Brown & Ryland, 2019). Fragmented services and staff shortages are limiting capacity to develop initiatives on partnership, collaboration and co-production in mental health with few opportunities for clinical staff to develop knowledge and expertise.

In Europe historically mental health care systems are moving towards deinstitutionalization, with the aim to decrease in inpatient care and a drive to develop community services (Becker & Kilian, 2006). This has meant that the financial resources necessary to introduce change in organisations is limited with healthcare budgets directed towards the development of community mental healthcare. Accordingly, considerable variations are seen across national mental healthcare systems, with variability in individual outcomes for service users, owing to different patterns of service development, use and service costs (Becker & Kilian, 2006).

As identified previously, there are changes in health service priorities with greater focus on SU involvement in planning, delivery and evaluation (co-production). However, this comes at a time where there appears to be reduced investment in mental health research for the development of this area. Castelpietra et al. (2020) identify that while the European Commission maintain that there has been a greater investment in mental health research funding across European countries, the actual funding allocated in Horizon 2020 programmes to mental health represented only 2.3%.

Partners could not identify clear policies on investment in peer to peer support and education. This resonates with questions that are raised by Silver & Nemec (2016) who identify lack of clarity on definitions of 'peerness'; contradictions in definitions of the role clarity on pathways and standards for career advancement of peer workers; peer support service model design and implementation, and integration of peer workers in other service models as barriers to wider adoption of peer roles. They also identify that funding for roles frequently requires achievement of outcomes for funders that may be at odds with 'the philosophy, principles, and best practices of peer services' (Silver & Nemec, 2016: 290).

User involvement in the context of finances

If we are to include greater inputs from people with self-experience (both individuals who experience mental health problems and those who care alongside them) the difficulties encountered to involve them and reward their involvement need to be overcome if this involvement is to move beyond the tokenistic. The experiences of trying to remunerate service users for involvement in service delivery are difficult. The integrations of people with experiences is also difficult as pool of 'experts by experience' is small and demand for involvement in projects is high. This can lead to high turnover of service user representatives, with mobility in projects, burnout, and therefore more tokenistic involvement. People's involvement can also be compromised when the attitudes of those participating have not fully embraced the principles of co-production.

Socio-cultural

Factors influencing the project from the socio-cultural perspective include stigmatisation, rights, demographics, the ability to recognise mental health problems in primary care and continued stigmatization of people with mental health problems in society remains an issue (Munizza et al., 2013). Whilst the notion of positive mental health and mental health promotion is gaining traction, many services remain 'disorder oriented' and language within the mental health field remains problem oriented.

The European Pact for Mental Health and Wellbeing (Wahlbeck et al., 2010) identified combating stigma and social exclusion as key objectives for action. The analysis of partners identified limitations in countries ability to provide social support for people with mental health problems. There is poor social awareness of threats against mental health across communities. Identified is a need to improve education to minimize stigmatisation and increase awareness of personal mental health. A key aspect identified in this regard is the need for social education regarding legal rights and protection for service users' welfare (Kożybska & Karakiewicz, 2016).

An acknowledged socio-cultural factor is the changing demographic of the population in Europe, with an aging population placing increased pressure on healthcare systems and finances, these pressures place limits spending in other areas like mental health.

An objective of improving mental health problems is the early recognition of symptoms in primary care. The levels of competencies in primary care regarding mental health is identified as a priority for the improvement of mental health outcomes. However as identified earlier, decreased educational opportunity for staff working in these areas affect the ability to identify mental health problems at an early stage, accordingly there is a need to improve the educational level for the early recognition of mental health problems and competencies for staff in working primary care.

Technological environment

In the field of technological developments in healthcare the WHO (2013) identify the need for strengthening information systems, evidence and research. Indeed, technology has opened new frontiers for health and social care. Recent systematic reviews of digital health technologies suggest that they provide opportunities and positive for monitoring, clinical assessment or as an intervention for self-management, adherence, therapy (Batra et al., 2017; Weisel et al., 2019; Josephine, Josefine, Philipp, David & Harald, 2017). E-learning courses, as a person-centred method of learning in relation to higher education, has also demonstrated benefits in the flexibility of learning, interaction, efficacy and knowledge (Sinclair, Kable, Levett-Jones, (2015).

However, the advent of the technological area has also brought increasing challenges for mental health. Increased use of social and digital media is associated with poor sleep quality, anxiety, depression and low self-esteem, with loss of the human connection also a feature (Woods & Scott, 2016; Shakya & Christakis, 2017; Tamir et al., 2018). Whilst computerisation in general health care has progressed at a pace in many countries, information flow between institutions supporting people with mental disorders is limited. Additionally, where there are private service providers and third sector and organizations are involved, information about their inputs is lacking. The recent pandemic has accelerated the use of digital technologies for digital communication and participation, facilitating digital engagement at unpreceded rates.

These discussions of the political and legal, economic, socio-cultural and technological, form the backdrop for the need to identify a new model of working, whereby people who use services, families, practitioners and the university can work together in an integrated way, to enhance and develop the environment of mental health care.

Co-production in mental health, overview of challenges and opportunities

Used in manufacturing since early 1960's, co-production refers to the involvement of citizens in the design and delivery of services (Turakhia & Combs, 2017). The concept and its underpinning principles have been applied in healthcare to increase public value (Clark, 2015; Batalden et al., 2015; Palumbo, 2016; Darby, 2017; Turakhia & Combs, 2017), yet in mental health its implications are vastly underexplored (Darby, 2017). Recently, the co-production of knowledge has begun to influence research, bringing together academics, researchers, and people with experience of mental health problems (King & Gillard, 2019). Service users and carers act as equal partners, whilst clinicians and researchers give up the power and control inherited through their historical roles (Slay & Stephens, 2013). Existing literature is focused on service user led research (Russo & Sweeney, 2016; King & Gillard, 2019), collaboration between academia and service users as researchers (Gillard, Simons, Turner, Lucock & Edwards, 2012) and coproduced services (Bradley, 2015).

Several definitions of co-production within the arena of health emerged, describing the process as a collaborative relationship that brings together professionals, service users, peer-workers, and volunteers with the view to improve services and quality of life for people and communities. More specifically, Kirkegaard & Andersen (2018) identifies co-production as a collaborative production of public services, across boundaries of participant categories, which may include professionals, service users, peer-workers and volunteers. Slay & Stephens (2013) describes co-production as a relationship in which professionals and citizens share power to plan and deliver support together, recognising that both partners have a vital contribution to make in order to improve quality of life for people and communities. Turakhia, & Combs (2017) believes that co-production is a collaborative approach, which demonstrates the benefits of working on a one-to-one basis with service users to design health care systems and improve care. A study conducted by King & Gillard, (2019) identifies co-production as high-value decision making dispersed across the team. Spencer, Dineen & Philips (2013), acknowledge the value of people's experiences to develop effective and sustainable outcomes.

Equality constitutes a fundamental aspect of co-production in that knowledge from all stakeholders is valued (Equality Act, 2010). Yet, it remains difficult to achieve given that the elite knowledge is privileged (Rose & Kalathil, 2019). In mental health, collaboration has evolved from subordination and dependency (New Economics Foundation, 2019) to co-production and parity, where both parties share power (Rose & Kalathil, 2019).

Boyle, Slay & Stephens (2010), identifies six areas within co-production: recognising people as assets and equal partners, building on their existing capabilities (knowledge building), reciprocity, peer support to transfer knowledge, blurring distinctions, and facilitating dialogue rather than delivering. Successful strategies include multi-disciplinary teams, improvement of communication strategies and a digital infrastructure to strengthen patient-provider relationships (Palumbo, 2016).

Co-production can be used to co-create health services and systems built on dialogue, transparency, collaborative patient-clinician relationships and the understanding of benefits/risks to achieve better outcomes for patients (Turakhia & Combs, 2017). The key benefits of co-production include improving social networks and social inclusion, addressing stigma, improving skills, and preventing poor health (Boyle, Slay & Stephens, 2010; Slay & Stephens, 2013) Working in a coproduced manner brings benefits to practitioners, who, also acknowledged greater job satisfaction, effectiveness and ownership (Spencer, Dineen & Philips, 2013). The involvement of service users in co-production alongside practitioners, contributes to identifying the need/problem, solution, and outputs which can lead to effective sustainable change (Spencer, et al., 2013).

Co-production can be performed at individual and collective level, yet it concerns the one-to-one relationship amongst patients and health professionals (Palumbo, 2016). However, this relationship poses challenges, such as professionals being dismissive or patients' reluctant to take part in the process (Palumbo, 2016). The power of hierarchies persists and is transferred across in user involvement where professionals act as experts disempowering those involved (Kalathil, 2013). The symbolical use of co-production creates ambiguity about what the users legitimately may perceive as real co-production (Kirkegaard & Andersen, 2018).

In the STRENCO project, it was anticipated that the use of co-production in the development of new knowledge in mental health education, would support social inclusion and increase the sense of involvement via a shared understanding, equality, and a dialogical approach. To overcome the negotiation of power, STRENCO project partners aimed for a co-production process focused on equality and parity by bringing all participants together to work as equals, whilst developing a shared understanding of what needs to be created and the commitment involvement.

Communities of Practice (CoP) in mental health

The concept of CoP initially was described by Lave & Wenger (1991) through the situated learning theory. The learning, meaning and identities of CoP were further developed by Wenger (1998). In situated learning theory, learning is not about an individual acquiring and applying a body of knowledge, but about the process through which the skills are acquired and applied (Lave & Wenger, 1991). Wenger (1998) defines communities of practice as 'Collective learning results in practices that reflect both the pursuit of our enterprises and the attendant social relations. These practices are thus the

property of a kind of community created over time by the sustained pursuit of a shared enterprise' (Wenger 1998:45).

According to Wenger (1998), the essential concepts for situated learning and community of practice theory are meaning, community of practice and identity**.** Meaning explains how members of a community make sense of past, presents and future interactions, which changes depending on the individuals' experiences (Wenger 1998). Wenger argues that the term community of practice should be simultaneously used as in the context of CoP both, the community and practice, are essential to exist. The community exists as long as the practice generates shared interest. Wenger's view of a community relates to cohesion, which emerge through mutual engagement (participation), shared repertoire (e.g. procedures, techniques, content) and joint enterprise (common purpose) (Wenger, 1998). Identity refers to how community members, by participating and negotiating meaning within a community, also understand themselves within the context of that community.

Rogers (2000) tested Wenger's principles of forming a community of practice for education purposes. He added further clarification on the essential requirements for mutual engagement, joint enterprise and shared repertoire. The result of mutual engagement is that members maintain their identity and share competencies with the group to create a common negotiated activity. During this process they form relationships. The relationships within these communities can be further explained using Putnam's social capital approaches in online communities, namely bonding and bridging (Putnam, 2000). Bonding exists amongst members of the community, who form strong relationships and are emotionally attached, whilst bridging aims for group diversity and weak ties amongst members, who share useful information.

Joint enterprise enables the community to expand boundaries and knowledge beyond the original ideas. In this process, members who might not share similar views have disagreements, which trigger further negotiation amongst the team. Shared repertoire refers to resources that members share and update (Rogers, 2000). Dobson & Fitzgerald (2006) consider that there are three inter-related components to communities of practice. Firstly, a 'Domain' or focus for activity. This guided learning, provides meaning and value, and offers a common identity for the group. The second element is 'Community', defined as a group of people who care about the domain and interact in practice and the third is 'Practice', which Kilbride et al. (2011) define as a mutual engagement of community of members in the activity of the domain.

The research of CoP in mental health, though limited, it highlights its effectiveness in advancing knowledge in the field (Cassidy, 2011). It provides a mechanism to bring expertise together in order to share knowledge on the best way to improve the quality of care for patients (Le & May, 2009), which aligns with STRENCO intentions.

Dobson and Fitzgerald (2006), claims that there is limited evidence on how to develop communities of practice. According to the literature on CoP emphasis should be placed on membership, individuals' commitment, relevance of members in enabling the acceptance of change, infrastructure, skills of the individuals and recourses available in achieving change. CoPs can be conducted face to face or virtually.

In the context of the STRENCO project, the practice included recognising people as assets and equal partners, knowledge and capacity building, reciprocity, peer support, dialogue and facilitation.

Methods

The Logic Model

A logic model is a summary diagram, which illustrates the pathway from intervention to outcome and provides a summarised theory of how complex interventions work. Logic models have gained popularity as an efficient tool in planning, monitoring, implementation of activities and in evaluation of outcomes and impact (Lando, 2006).

The logic model concept derives from a similar approach to the theories of change (Kneale, Thomas, & Harris, 2015). It demonstrates in a diagrammatical format the underlying theory of interventions and delineates how resources and activities are linked with the desired outcomes, which helps with project management, resource allocation and strategic planning (Parsons & Jessup, 2012; Mills, et al., 2019).

Though logic models can take many shapes for different contexts, the basic features are resources or inputs, activities, outputs, and outcomes (Van Koperen et al., 2013; Mills, Lawton & Sheard, 2019).

The benefits of using a logic model include understanding of theories on how interventions work, elucidation of which theory triggered which outcomes, a summary of its underpinning elements and generation of hypothesis (Rogers, 2008). Over the years, logic models have been used by teams to build consensus amongst complex projects. Within this project, it was used to draw consensus amongst a multidisciplinary team of academics, students, mental health service users/carers and other members on a coproduced tripartite approach in STRENCO.

Participatory Action Research Approach

In Action Research, participants collaboratively evaluate situations and make subsequent changes until a satisfactory solution is achieved (Baskerville & Wood-Harper, 1996). As a modality of action research, Participatory Action Research is a variant of the action research process that involves applying egalitarian principles of participation of a community to transform aspects of a situation or a structure (Coghlan & Brannick, 2014). Although not being a research piece, the STRENCO project has adopted principles drawn from Participatory Action Research in its overall development and in producing its outputs. Participatory Action Research is a methodology that 'promotes collaboration, empowerment and equal partnership amongst contributors, with a shared understanding that the expertise is located within individuals who possess the lived experiences of the topic at hand' (Ampartzaki, et al 2013). The approached is characterised by the involvement of those who are the focus of research in the process, working collaboratively with researchers (Koch & Kralick, 2006; McIntyre, 2008; Robson, 2011). As such, the approach lends itself to the running of the STRENCO project in developing a model of working and a framework of competencies for mental health. The Participatory Action approach can

generate insights on power and powerlessness on the involvement of groups in making decisions, a concept central to co-production (Coughlan & Brannick, 2014). As an approach it provided an opportunity to address real-life problems, such as those identified in the situational analysis, and help find viable elements that might improve practices and modes of working (Ampartzaki, 2013)

The principles appeared to be a good fit with the overall ideals of the project, which sought to find ways that could integrate the knowledge of mental health service users into the development of ways of working in mental health. It was adopted due to the ability of the approach to provide for inclusiveness of views and an egalitarian platform, where all participants could be considered as both competent and capable of participating in the development of the project's outputs and materials, even though this representation of participants may have happened in different modes and at different levels throughout the project. Using the principles of the approach, over the course of the project it has allowed for generation of knowledge by reflecting and analysing the ways of working used during the project; reflection upon actions and strategies for working in distinct ways (Ampartzaki, 2013). With the use of communities of practice as the approach for the development of knowledge in a diverse and geographically distance consortium, the marriage of participatory action research, communities of practice and a philosophical standpoint of co-production appeared to be the 'best fit' for the development and running of the project, as, it investigates processes, relationships and dynamics exhibited in national CoPs and IP weeks.

The reflective cycles entailed analysis of the following sets of data:

- field notes from 6 transnational project meetings, and 22 formal online project meetings
- 2 project audits
- IP participants reflections

Reflection forms a critical component of the learning process across participatory methodologies, including action research (Davison, Martinsons & Kock, 2004; Coghlan & Brannick, 2013).

Qualitative data provided an opportunity to interrogate change, gathering a deeper understanding as to the drivers that influence the 'tripartite' community approach, whether this highlights collaboration, shared repertoire, practice, and ultimately the impact of this approach.

A framework analysis method was adopted to analyse qualitative data (Lacey & Luff, 2007; Krueger & Casey, 2009; Miles, Huberman & Saldana, 2013). This study followed Ritchie & Spencer (1994) five-step process for data analysis (familiarisation with the data, development of framework, indexing, charting and mapping). The priority themes were established through literature review and refined using the data collected.

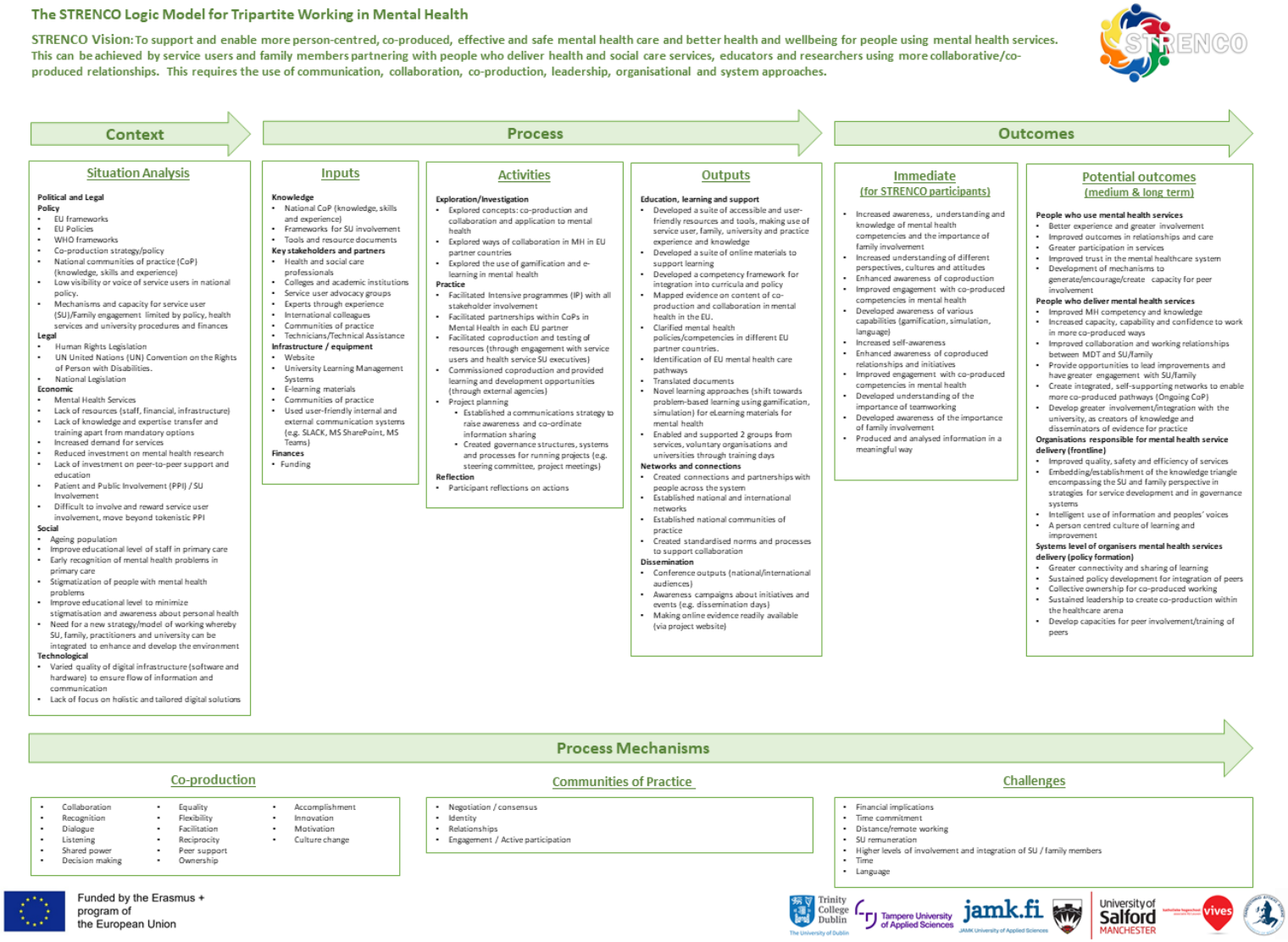
The STRENCO Logic Model for tripartite working

The logic model provides a framework to map the project context, the processes and outcomes. The development of the logic model for STRENCO followed an iterative process, which involved:

1. Reviewing and discussing the context to understand and evaluate the challenges and opportunities available in new programme design (situation analysis section above)
2. Scanning and synthesising existing literature to underpin co-production and CoP approaches (sections above)
3. Analysing field notes and participants reflections to identify and validate inputs, outputs and outcomes. In addition, the data was used to validate CoP and co-production-process mechanisms (identified in step 2)
4. Ongoing discussions with STRENCO partners to achieve team consensus

As per Participatory Action Research principles, different Logic Model versions were created as part of the action research process. This report presents the final version and the next sections describe and validate the model. It combines the situational analysis, existing literature, and field notes and participants reflections to validate the model.

Figure 1 The STRENCO Logic Model for tripartite working



STRENCO Context

The context forms the first aspect of the logic model (Figure 1). It reflects the conditions (reality) in which the programme works.

At the start of the project, a PEST Analysis was performed (Table 1, page 9) to determine the context in which the project was developed. The assessment highlighted multiple factors influencing national and international developments in mental health, including policy and frameworks, pre-existing social context, co-production and CoPs, service provision and infrastructure, financial implications, and education.

The analysis of data also highlighted local contexts similarities and disparities, overlap in competencies across countries and multiple skills and talents health professionals develop

> *'really enjoyed being part of the group and activity. Useful hearing other perspectives on collaboration and mental health provision. Helped me to connect with others find common ground but explore difference in the way we work. It was safe, friendly and supportive with lot of discussion about key issues.* (IP 1 Reflections)

> '*There were a lot of overlaps in the competencies between countries… This exercise made me realize how multi-talented a mental nurse should be everywhere...*' (IP 1 Reflections)

> *'I found it interesting to see that there were a lot of overlaps in the competencies and that there are some really good topics/ indicators in there which I feel could really change the way how I would work in the (mental) health field… opens possibilities to see wider view and step out of the "box".'* (IP1 Reflections)

STRENCO Process

The second aspect of the logic model refers to the inputs (resources), activities (things done) and outputs (results of inputs and activities) required to address the project aim.

STRENCO partners discussed and agreed the inputs necessary to complete the activities (Figure 1, Inputs). Tripartite working required key stakeholders and partners to share knowledge and experience. Within STRENCO, CoPs enabled key stakeholders and partners with a common interest in mental health to participate in the process of generating knowledge (shared repertoire). Through interaction, members of the community shared knowledge, skills and experience and built group identity. The team used digital tools and platforms to promote knowledge creation, dissemination and communication. An interactive website was designed to promote the resources coproduced within STRENCO. At project

management level, digital technologies allowed the team to o remotely participate, collaborate and store project related documentation.

The activities (Figure 1, Activities) were aligned with the project objectives, amongst which strengthening co-production, collaboration and CoP through exploration, practice, and continuous reflection. During the situation analysis phase, existing evidence was identified to understand the concepts of co-production and collaboration in mental health in EU partner countries.

To maximise participants engagement and motivation, the principles of gamification were explored and applied within the project. Defined as 'game-based mechanics, aesthetics and game thinking to engage people, motivate action, promote learning, and solve problems' (Kapp, 2012:10), gamification was recently adopted by clinicians, academics, and educators to motivate and engage end-users using game elements and mechanics. Games are known to motivate people in otherwise nongame scenarios and engage users in high interaction (Basten, 2017). Gamification remains a developing approach for encouraging user motivation, engagement and enjoyment in non-gaming, computer-mediated environments with an early collection of empirical work supporting its potential for beneficial effects in certain contexts (Seaborn & Fels, 2015), including health and wellbeing (Cheng, 2020; Flemming, 2017).

Practice in the context of STRENCO reflects the activities carried out to meet the project aims. At outset, three IP weeks were planned at the partners' institutions, however, the COVID-19 pandemic forced changes. (Table 4). IP 3 was initially planned to take place in Tampere University of Applied Sciences (Finland) but given the travel restrictions, the materials were designed for online dissemination.

Table 4 IP weeks

	Location	Themes
IP 1	University of Salford, UK	Collaboration / doing things together; eLearning and e-Mental health Competencies for collaboration
IP 2	VIVES Belgium, Kortrijk	Coproduced mental health promotion, co-production and family participation in MH care
IP 3	Digital materials	Complex needs: eating disorders, personality disorders, activities of daily living, psychosocial skills and how to use digital services, cyber security, and use of virtual reality

Project management formed an important aspect of tripartite working within an international context. It involved having governance structures, systems, processes, and a communication strategy to effectively coordinate and manage the project. The key aspects identified in the data include choosing the right communication systems, to avoid difficulties, timely dissemination of resources (meetings minutes), and continuous planning.

The team explored systems such as Adobe Connect, Slack, MS SharePoint, MS Teams, Zoom to effectively communicate and share information amongst project partners. Adobe Connect was used in the initial stages of the project for online meetings. As new members joined, the platform posed difficulties such as licencing or firewalls blocking access. Zoom was used as an alternative solution. The introduction of GDPR in 2018 triggered new data protection challenges and the team opted to centralise documents on SharePoint and use MS Teams. Slack proved an effective tool for communication, interaction, and engagement.

During the IP, reflection formed part of participatory action research data collection and an activity that allowed participants to explore and learn from their perceptions and experiences.

The activities undertaken resulted in several outputs, linked primarily to the STRENCO project outputs (Figure 1, Outputs). A suite of accessible, user-friendly and co-produced resources and tools have been developed, with input from service user, family, university and practice experience and knowledge. The key resources (eLearning material, competency assessment tools and the logic model for tripartite working) were translated and digitised to ensure wider access. An interesting aspect that emerged from the data was the novel learning approaches used to increase motivation, amongst which gamification and simulation. Examples of gamification include an innovative approach to teaching mental health promotion using Maaklab, an engineering department and co-production with service users, family members, students, practitioners and academics. Design Thinking is used as a process in engineering to stimulate problem solving and fitted well with the projects gamification ethos and learning by doing. Simulation was utilised during IP week 2 to create scenarios using role play. The roles represented the SU, family, professionals and students enacted each of the roles. Then, they received feedback from a panel of service users, family members and academics. Subsequently, the activity allowed the students to understand multiple perspectives. Participants appreciated these novel learning experiences:

> *'Students were happy, enthusiastic about the whole project, happy that the approach was different than what they are used to do (maaklab, simulation).'* (Project Minutes)

> *'Maaklab, role play were the most outstanding activities. Big appreciation for all differences*' (Project Minutes)

'The simulation sessions have been very interesting for the students especially the part of debriefing' (Project Minutes)

Training formed a fundamental aspect of STRENCO, delivered via the IP weeks, and additional training days held at partner institutions (enabled and supported 2 groups from services, voluntary organisations and universities).

The project was set up with the intention to facilitate national CoPs. Analysis of field notes acknowledged the existence of CoPs and highlighted the various practices adopted, thus being influenced by the context in each country. For example, partners from Belgium used a 'world café methodology, in which students, service user, professionals and academics in an equal distribution of roles shared individual experiences and knowledge. In Finland, Tampere, UAS, representatives from public mental health services (Pirkanmaa Hospital District and the City of Tampere), from local family member's organization (Pirkanmaa Association of Families of People with mental illness) and from local Mielen NGO, which is educating experts by experience and coordinates activities in each area, participated in this project. In Ireland, TDC, the initial plan was to partner with advocacy networks. The challenge was that the service user left the organisation, though it remained involved in STRENCO CoP in different roles, advocate, tutor on a peer advocate preparatory programme and recovery college facilitator. In the second year of the project the service user advocate was joined by a family member, employed by the HSE as a service user lead in the Community Health Organization affiliated to the University. Clinical staff (3 representatives Advanced Nurse Practitioner & Nurse Practice Development Coordinator and a clinician from practice) and students (5 ECTS to students for award of degree) joined. The CoP met 6 times face to face and online after the COVID-19 pandemic emerged. In Greece, linking with a service user group was challenging. The partnership with mental health care settings, especially one of the NGOs providing community mental health care services proved helpful. The NGOs shared a similar working philosophy, which was focused on co-production. In this setting, sustaining the CoP was often difficult given the system bureaucracy. In UK, UoS, the initial CoPs meetings involved service users, carers, practitioners, students, and academics. Participants shared previous experiences of being involved in CoPs and explored co-production in mental health. The community changed membership throughout the project.

CoPs and the IPs, facilitated the development of national and international networks, through which new partnerships and connections emerged:

'During the IP all the participants (students, academics, professionals and service users) worked in mixed international groups and created content for eLearning environment. (Project monitoring tool)

'Great opportunity to collaborate with people from other countries and exchange ideas about how we manage mental health in our country' (IP 1 Reflections)

Contact with other students; it was good to learn more about them. (IP 1 Reflections)

However, participants identified that in some instances, at the start of sessions, language constituted a barrier to effective communication between the groups or within the groups. As the collaboration progressed, language was no longer a barrier

'Getting into a group-conversation with the different people can be difficult in the beginning (mostly because of the language barrier) but in the end we all found a common ground, we understood what the other members were saying and everybody could say what he wanted to say, which I think is very important.' (IP 1 Reflections)

Norms and processes to support co-production and CoP emerged from the projects and it will be discussed in the "Process Mechanism' section.

Dissemination of resources formed a key component of STRENCO. Throughout the project, the partners presented at national and international conferences, facilitated awareness campaigns and created an online learning resource, available on the STRENCO website.

STRENCO Process Mechanisms

In the context of STRENCO, the process mechanisms (Figure 1, process mechanism) encompass all factors considered essential in understanding the process of co-production using the tripartite approach. The factors were identified though a literature review, validation through data and team consensus.

Co-production

The process of co-production, within the STRENCO project was influenced by a series of factors including collaboration, recognition, dialogue, listening, shared power, decision making, equality, reciprocity, peer support, flexibility, facilitation, ownership, accomplishment, innovation and motivation. The factors, alongside supporting evidence, are presented below.

During the IP weeks, participants acknowledged that collaboration remains an underutilised method to improve services and education in mental health. Often, they used the term 'working together' in conjunction with collaboration.

'Liked the notion that collaborative is an underutilised opportunity in supportive recovery also the nature of undergraduate programmes in nursing.' (IP 1 Reflections)

> *'Collaborative working began immediately, and we all participated in producing our presentation, True co-production. The presentations where all informative and enjoyable I am grateful to have been given the chance to attend 2 days.'* (IP 2 Reflections)

> *We have chance to explore in real time the meaning of collaboration. We worked together and we made a presentation based on our cooperation and not some references we found online.* (IP 2 reflections)

Through collaboration, IP weeks participants recognised the different perspectives, the variety of care systems and policy. Furthermore, they emphasised that the clients and families should be recognised, alongside multidisciplinary teams.

> *Lots of overlaps in the competencies I think that there are some really good topics/indicators in there, which I feel could really change the way I would work in the mental health field* (IP 1 Reflections)

> *The important input was getting a picture of other people's perspectives on the competencies and how they can be used in practice.* (IP 1 Reflections)

> *The massive family involvement of Greece was an opener. I am from Belgium and loneliness is a big problem*. (IP 2 Reflections)

IP week participants worked in an informal way, engaged in dialogues, listened and respected each other, sharing power and taking decisions as a group.

> *The teamwork was interesting and informal, you weren't pressure, but you could give your input in your own time and in your own words. There were no barriers.* (IP 1 Reflections)

> *We listened to each other; it was the basis of what collaboration means. Great experience.* (IP 1 Reflections)

> *Useful hearing other perspectives on collaboration and mental health provision. Helped me to connect with others find common ground but explore difference in the way we work. It was safe, friendly and supportive with lot of discussion about key issues.* (IP 1 Reflections)

In this process, IP week participants took part as equal partners, working in reciprocal relationships and sharing mutual responsibilities. They took ownership and accountability of what they contributed to the process and the project

> *Everybody was able to say what they wanted without a right or wrong answer.* (IP 1 Reflections)

The amount of respect there was from everyone we listened and learned (IP 1 Reflections)

Developed ideas that have the same goals although we come from different cultural backgrounds. Brilliant activity for collaboration (IP 1 Reflections)

'I learned to relax and not to try control everything. I learned to appreciate other people's views. (IP Reflections)

Flexibility was highlighted as necessary within the coproduction process, during the IP weeks as well as the project overall

Sometimes it was necessary to adapt the programme. This is normal in these kind of projects (dynamic) (Project monitoring tool)

A facilitator guided the IP week sessions and dialogue to ensure that the objectives are met, and stimulated conversations and critical thinking. Using problem based learning, the facilitators were chosen based on the purpose of sessions. They brough in different expertise, for example maaklab experts led the gamifications activities, or mental health lecturers facilitated the training days. The STRENCO project partners felt that the facilitator role is intrinsic to the co-production process.

Peer support was an underpinning principle of co-production and CoP, also evident in the data collected during the IP weeks. It relies on members engaging and supporting each other in the process of generating knowledge.

Really enjoyed being part of the group and activity. Useful hearing other perspectives on collaboration and mental health provision. Helped me to connect with others find common ground but explore difference in the way we work. (IP 2 Reflections)

I was a little bit nervous but the cooperation with other students was excellent, I learned allot of things about mental health in other countries. (IP 1 Reflections)

The shared repertoire achieved as a result of participation and negotiated meaning gave IP week participants a sense of accomplishment and they felt that their competencies (ideas and perceptions) were represented and used towards achieving a common goal

I learned to present better, allowed myself to be creative in the group and actually becoming fonder to group work … I am proud of what we made, and I am looking forward to present it to the people tomorrow… we achieved and learned a lot. (IP 2 Reflections)

Other factors that influenced the process of co-production during the STRENCO project were innovation and motivation, which can be a result of the innovative activities used to form a more participative and inclusive approach, which in return stimulated motivation.

> *I like the innovation part where we could join and do presentations about our countries*. (IP 2 Reflections)

> *Most of the learning activities were new and innovative to them and they made them more motivated to get involved in the IP. This whole experience will help them develop as health professionals and as person in general.* (Project monitoring tool)

A fundamental culture change is necessary to include co-production in clinical settings. Participation in STRENCO, gave participants the courage and ideas of how to implement that culture change in their respective countries

> *I found it interesting to see that there were a lot of overlaps in the competencies and that there are some really good topics/ indicators in there which I feel could really change the way how I would work in the (mental) health field… opens possibilities to see wider view and step out of the "box".* (IP 1 Reflections)

> *I can return to clinical practice with new knowledge and improve my skills and that of the culture within the clinical setting* (IP 1 Reflections)

CoP

The formation of CoPs involves continuous negotiation of meaning and identity. Within STRENCO project, negotiation of identify (individual and community) and boundaries were continuously explored.

> *Helped me to connect with others, find common ground but explore difference in the way we work.* (IP 1 Reflections)

> *Some day we start working later than was mentioned in the originally timetable. The change was agreed with the participants* (Project Monitoring tool)

Participants had to coordinate multiple perspectives, developing their skills and identity. Identity in CoPs emerges through participation and reification and it is constructed through negotiation of meaning for participants.

Too many people from England and they dominated in the group for the group work. Interesting to hear stories, situations from other countries, but sometimes difficult to start (IP 1 reflections)

Really enjoyed being part of the group and activity. Useful hearing other perspectives on collaboration and mental health provision. Helped me to connect with others find common ground but explore difference in the way we work. It was safe, friendly and supportive with lot of discussion about key issues. (IP 1 Reflections)

The value of relationships was reiterated by the IP week participants and STRENCO project partners.

My group was so friendly to me, and we make a good project. (IP 1 Reflections)

Working and learning together is one of the most important results for participants. (Project monitoring tool)

Engagement was fundamental to forming national CoPs and during the IP weeks. It describes the active engagement to negotiate meaning, contribute to enterprise and create sharable artifacts.

They actively participated in all planned activities, workshops, group work, creating of materials and presentations (Project monitoring tool). *They participated actively in the workshops, connected with other students, academics and service users/carers. They also participated in the COP's* (Project monitoring tool)

STRENCO Outcomes

The next stage in development of the model highlights the outcomes and assumptions regarding links between different components. The outcomes were divided into short-term outcomes (exhibited by participants in STRENCO), and long-term outcomes (potential outcomes) (Figure 1, Outcomes).

Short-term outcomes have been classified as those that impacted immediately or specifically on individuals involved in the tripartite co-production within STRENCO. Data analysis revealed that participation in STRENCO led to awareness, understanding and knowledge of mental health competencies, and the importance of family involvement.

I can return to clinical practice with new knowledge and improve my skills and that of the culture within the clinical setting (IP 1 Reflections)

The massive family involvement of Greece was an opener. I am from Belgium and loneliness is a big problem. (IP 2 Reflections)

Participants acknowledged an increased understanding of different perspectives and attitudes related to mental health

> *The important input was getting a picture of other people's perspectives on the competencies and how they can be used in practice.* (IP 1 Reflections)

> *A great insight from different team members regarding experiences and attitudes to mental health treatment. The current competencies used where an excellent gateway to our conversations.* (IP 1 Reflections)

Through participation in STRENCO, participants were exposed to co-production and coproduced competencies in mental health, which increased their awareness of co-production and improved engagement with mental health competencies

> *Co-production is a really good method each partner can bring in ideas so it's more valuable.* (IP 1 Reflections)

During the co-production process, IP week participants developed awareness of various capabilities, for example learning about new methods, improving language, team work, or being exposed to different cultures

> *Gamification in mental health is very new to me and I will be interested to see how it is developed in the future.* (IP 1 Reflections)

> *'I learned to relax and not to try control everything. I learned to appreciate other people's views. I learned to speak more fluent English and not to worry if I don't pronounce everything correctly. I don't know how I could have done things better. Maybe I could have been more social between groupworks'.* (IP Reflections)

As the team started to collaborate, participants developed awareness of working relationships, different cultures, norms and meaning. They valued teamworking more

> *Collaborative working with these active people here is a sign that we really can improve things and change ideas!* (IP 1 Reflections)

> *I believe teamwork is the main theme from this week because in order for co-production to occur successfully people must be able to work together regardless of discipline of background.* (IP 2 Reflections)

> *I learnt mostly about working together I learnt about different aspects about collaboration.* (IP 1 Reflections)

In addition to the immediate outcomes exhibited by participants in the IP weeks, the STRENCO project partners envisage a number of long-term outcomes (Figure 1, potential outcomes), which can be achieved by adopting the Logic Model for tripartite working and adapting to the context.

STRENCO Challenges

The next stage in the development of the model was to identify the challenges encountered throughout the project including the IP weeks. The challenges should be interpreted not just as barriers to the implementation of the project but opportunities to create improved project planning and implementation of future international projects.

Ensuring equal spread of budgets and movement of finances was an important challenge. Funding set out in the initial project plan did not include funding for service user involvement and travel. Movement of funding to other parts of the project was also difficult. Additionally, sufficient funding should be available prior to activities (such as IPs) taking place, to ensure members do not have to self-fund in the first instance. Budgets have to take into consideration catering requirements. As highlighted in the situational analysis, service users and carer renumeration is a long-standing issue in co-production.

STRENCO partners faced similar challenges:

> *There was no budget built into the project plan for service user involvement therefore making it difficult to ensure participants were adequately renumerated.* (Project Monitoring Tool)

> *This part of the project has proved difficult and there are still payments outstanding for the representative, due to potential tax liabilities* (Project Monitoring Tool)

Challenging behaviours were displayed during IP weeks by members of the group. It is important to note the intensity of the IP weeks and the additional pressure this may place on people who use services. Additional support for people with mental health conditions attending the IP weeks should be factored into the planning of co-production.

> *Inappropriate behaviour by one guest service user towards one student. As a student in mental health nursing, the student was aware of potential problems from experiences in clinical practice and was understanding of what had happened.... assess peoples mental state over the period of their involvement so as to pre-empt this for the future* (Project Monitoring Tool)

Participants reported limited experience of co-production (in practice) as they had received limited involvement in co-production in theory and practice prior to the IP weeks. It is important that participants were made fully aware of the key concepts prior to getting involved in IP weeks.

> *I have seen slight elements of it in many instances while on placement but very few genuine examples of co-production - especially when considering the family involvement*. (IP 2 Reflections)

> *I haven't seen much co production in my area but small things like including family in the service users care and promotion of self-management for service users.* (IP 2 Reflections)

During the IP weeks, some participants (mainly service users and carers) decided to no longer attend. The reason for dropping out are not fully understood. However, this could link to 'challenging behaviour displayed during IP weeks'

> *Dropouts of several services-users and one issue with behaviour of one service-user.* (Project Monitoring Tool)

The language barrier due to multiple countries working together was found to be a challenge for some students, students were encouraged to speak in English, however as this was not their first language some felt apprehensive communicating in English thus effecting their confidence initially.

> *It made me a little frustrated because my English is not very good (*IP 1 Reflections)

Time/availability of participants and ability to complete workload, due to the IP weeks taking up nearly a full week of participants time, it was sometimes difficult to release staff/students to attend the IP weeks. There was an increase in the workloads of academic staff due to coordinating, planning and delivering the IP weeks. Students also felt that more time should have been provided in the IP weeks to complete certain activities such as 'simulation'.

> *Creating time and space for engagement to happen. This will be necessary for everything else to grow. If we cannot provide time, we will never be able to listen and never have the opportunity to hear.* (IP 1 Reflections)

> *Our University did not participate in the IP as planned in the proposal. One teacher instead of two took part in the IP and three students instead of five.* (Project Monitoring Tool)

> *Give more time for activities, I would have liked to have more simulation practises* (IP 2 Reflections)

Distance working between countries was highlighted as an issue in terms of working together as the project team could not meet in person on a regular basis. This was overcome by the use of digital technology.

> *How we work together due to different countries, Discussion how to work online with documents and meetings.* (Meeting Minutes)

The use of technology to enable remote/distance working

> *Difficulties being encountered with Adobe Connect platform for online meetings.* (Meeting Minutes)

GDPR /Data Protection implications due to remote working

> *Impact of GDPR and document retrieval and linkage in Slack also considered. Suggested that MS Teams could offer a harmonised solution with conferencing, chat* (Meeting Minutes)

The COVID-19 pandemic remained one of the most provocative challenge faced during the STRENCO project. It forced strategic and operational changes. As travel and face to face meetings were no longer permitted, the project team opted for regular online meetings. Building good relationships among partners and trust helped to overcome the distance challenges, working efficiently within online meetings, which were sometimes shorter in order to proceed with the work, using any available platform for communication and sharing of information.

Discussion

The STRENCO Logic Model for tripartite working (Figure 1) extends current evidence by providing pragmatic guidance on how to co-produce in mental health. It provides a diagrammatical model to guide co-production with service users, family members, carers, experts by experience, clinicians, academics and students to strengthen competencies for working in mental health. The model was conceived and tested using the knowledge, understanding and experiences developed over the course of the STRENCO project. Accordingly, it presents practical evidence for working in mental health in a more co-produced way. This is complementary to existing evidence on co-production in mental health (Slay & Stephens, 2013; NDTi, 2016).

The STRENCO Logic Model for tripartite working offers insights into how context, process and outcomes are intertwined within co-production. Based on the experience drawn from the STRENCO project, the team offers reflections on tripartite working in mental health, benefits and potential weaknesses of working in a co-produced manner.

Tripartite working in mental health

The process of working in a co-produced manner can be visualised as a jigsaw with the key components (pieces) including context, process and outcomes. The process mechanism should be considered as key factors that influence co-production.

'Context' (Figure 1) is a pervasive force that is influential to the success of projects. Whilst the role of context is recognised in the NDTi (2016) guide, little direction about how to accommodate contextual factors within the co-production process exists. PEST analysis provides a practical framework to capture political, legal, economic, social and technological evidence and team experience at both national and international levels. It captured understanding of geographical variations in policy, co-production, variety of funding models and service provision. Furthermore, as noted through data analysis of IP weeks reflections, it highlighted the variety of policy, healthcare systems and overlapping in mental health competencies across countries.

The 'Process' (Figure 1) highlights the inputs and activities required to trigger the outputs and subsequent outcomes, within the identified context. The majority of intended outputs and associated outcomes were achieved during STRENCO, which strengths the validity of the proposed model.

'Process Mechanism' (Figure 1) describe the factors influencing the process. In the case of STRENCO project, collaboration, recognition, dialogue, listening, shared power, decision making, equality, flexibility, facilitation, reciprocity, peer support, ownership, accomplishment, innovation, motivation

and culture change were identified as fundamental to the process of working in a co-produced approached.

The findings from STRENCO co-production process aligns with that of Cahn's four core values, in that people are recognised as assets, their involvement in no longer taken for granted, and there is reciprocity and investment in social capital (Cahn, 2008: 31)

As a model, the STRENCO way of working created a mechanism in an international context, whereby six international consortia (CoPs) and shows a way where it is possible to work in a co-produced way with service users, family members, carers, experts by experience, clinicians, academics and students, collaborating to co-create knowledge and learning to strengthen and improve competencies in mental health. The Communities of Practice (CoPs) in each of the six partner institutions in the five countries acted as *'think tanks'*, both for the development of the Outputs on the project and for the running of the associated Intensive Programmes for students and teachers.

All stakeholders were valued as equal contributors, who shared power and contributed in the decision-making process (Rose & Kalathil, 2019). They worked in both formal and informal ways, listening and respecting each other. Reciprocity remained a key determinant throughout co-production (Boyle, Slay, and Stephens, 2010), in that participants mutually exchanged knowledge and experiences. This then led to peer support and social learning.

The role of facilitators in the IP weeks was intrinsic to stimulating engagement and dialogue. The facilitators (field specific experts, mental health lecturers) facilitated the training days. As facilitators focus on the learning environment of the community, they requires a good knowledge and communication skills to meaningfully interact with members of the community (Wenger et al., 2002). A degree of flexibility was required throughout the IP weeks and project to allow space for unforeseen situations.

Recognition of people who use the services and harnessing the power of their networks was identified as an intermediate level of co-production by Needham & Carr's (2008). In the context of STRENCO, this was extended to the variety of healthcare systems, policy and competencies, this way reflecting the tripartite collaboration between countries and national contexts. As a part of the process, all participants took ownership and accountability of tasks contributing to the development of resources (shared repertoire), which can lead to a greater sense of accomplishment.

Benefits of co-production and CoPs

Seen as beneficial in the process was the involvement of stakeholders with existing knowledge and experience in the co-production process serving as a catalyst to trigger positive outcomes (Boyle, Slay

& Stephens, 2010; Slay & Stephens, 2013; Spencer, Dineen & Philips, 2013). The outcomes element of the STRENCO Model (Figure 1), strengths the evidence for working in a co-produced way.

In mental health, the co-production process is focused on achieving parity and equality amongst participants, through sharing power, norms, roles and relationships (NDTi, 2016).

CoPs provided a vehicle for regular engagement and for the continuity of mutual relationships. Adopting novel learning approaches, is also seen as a manner to encourage cross fertilisation of ideas between stakeholders. This integration of participants provided for more egalitarian interaction amongst participants as gamification and simulation encouraged provided a newfound motivation and more active participation, here boundaries dissolved, and no consideration was given to medicalised identities.

Another positive aspect of the STENCO communities of practice is that participants negotiated a 'common ground' (IP1 Reflections) and their yielded their identities in an attempt to create the correct condition for co-production to work, therefore mitigating the risks of institutional rules, roles and cultural norms expected to be followed (NDTi, 2016).

STRENCO project partners have adopted an informal educational strategy to facilitate social learning. The notion of situated learning within a community of practice is important when service users, carers, clinicians and the university, as partners facilitate creation of knowledge and seek ways of working. As learning is linked to participation in the community of practice, participants learn through trust, relationships they form and shared repertoire (Lave & Wenger, 2002). All of these elements were visible within the STRENCO project. Participants in STRENCO IP weeks and national CoPs brought personal knowledge and experiences related to mental health, which was then extended through participation in STRENCO. They reported developing awareness, understanding and knowledge of mental health competencies, and the importance of family involvement. In addition, participants reported self-awareness ('*learned to relax', to appreciate other people's views', 'I feel could really change the way I would work)*, an important aspect of personal development, co-production and recovery journeys. This might have been triggered by the reflections embedded within the IP weeks and negotiation of own/community identity.

Challenges

Working in an international context to co-produce mental health competencies posed challenges. From the perspective of project managers/academics, financial implications, time commitment and distance/remote working remain one of the most difficult aspects. Remuneration of service users and carers constituted a significant challenge.

Another potential barrier was the time-consuming nature of co-production that requires active engagement, coordinating, planning and delivery of project, IP weeks and continuity of CoPs. Furthermore, participatory research requires trust and capacity building, which requires more time from stakeholders. Distance working between institutions added an extra layer of complexity. COVID-19 had significant implication on academics' workload, which then impacted on their availability to participate in the project. Sorter online meetings and ongoing discussion via Slack/emails enabled academics to meaningfully contribute and progress.

A significant limitation in the project was creating mechanisms for the higher levels of involvement and integration of service users and family members in projects such as STRENCO. From the very first meeting the most notable absence was that of the service user (SU) voice in the application process, which then translated into plans for implementing the project. The nature of the project call and the funding model in this regard proved a limitation. The provision of tight financial parameters and categories for the inclusion of all stakeholders as a part of the process proved a challenge, requiring the utilisation of creative measures to solve the problems.

For students, the language barrier was the most challenging aspect, as some felt apprehensive communicating in English, yet through co-production their confidence increased, and one participant even reported an increase in language proficiency.

Additional support for service users involved in the IP weeks should be factored into project planning.

The introduction of GDPR /Data Protection Act (2018) had implications for institutions storage of project related data/documentation had to be effectively managed to ensure integrity, confidentiality and availability.

It should be highlighted that the STRENCO Model for working has needed to take into account a geographic base that spans the four corners of Europe. It comes from a diverse base of mental health care, with different systems of care, each in different states of change. Yet, despite these diverse variables and elements evidenced in previous research, such as competing priorities, goals and interdisciplinary conflict between the stakeholders in co-production, in the case of STRENCO, trust and good working relationships among partners helped to overcome the distances and challenges. All of those involved in the STRENCO Project entered with a common purpose, to strengthen competencies in mental health, it became a goal which all stakeholders ultimately shared.

Conclusion

The STRENCO Logic Model, a Tripartite Model for working in mental health was an outcome of an iterative process aligned with a participatory action research approach. It joined theory with practice, in the development of a guide for working in co-produced ways with service users, family members, carers, experts by experience, clinicians, academics and students, to strengthen competencies for working in mental health. The development of the model encompassed research evidence, project materials, data from meetings, minutes, reflections and project reports from the inception to the conclusion of the project. It was developed in the context of EU policy emphasising the role of research, education and practice as co-creators in developing new approaches for working. The principles of Communities of Practice influenced not only the development of national CoPs, but the whole STRENCO project, which acted as to act as a community of practice in itself that facilitated the creation of knowledge and sought new ways of working. It strengthened working relationships and stimulated active participations and sustained engagement.

We recommend the application of this model to guide, plan, implement and evaluate co-production and to support and enable more person-centred, co-produced, effective and safe mental health care and better health and wellbeing for people using mental health services. We support the use of Communities of Practice, as means of situated learning, regular engagement and the continuity of mutual relationships. We also recommend using a participatory approach to inform the development of logic models in their applicability and relevance. The utility of this approach has also been seen by Afifi, Makhoul, El Hajj & Nakkash (2011) in its application for youth mental health. We would also like to signal caution about the possibility of challenges of working in a co-produced way such as funding, well-being, renumeration of service users and carers, time commitment and other unforeseen events (e.g. COVID-19). Fortunately, technology if appropriately chosen and used can remove barriers, including distance/remote working, ongoing communication and collaboration. Working this way will ensure that the outputs and outcomes of projects can be fulfilled.

Recommendations

Guided by the knowledge, understanding and experiences developed over the course of the STRENCO project, we recommend the following:

- The application of this model to guide, plan, implement and evaluate co-production and to support and enable more person-centred, co-produced, effective and safe mental health care and better health and wellbeing for people using mental health services.

- Examine the context in which the project is developed (situational analysis) to determine potential constrains and pitfalls.

- Use of Communities of Practice, as means of situated learning, regular engagement and the continuity of mutual relationships.

- Adopt a participatory approach to inform the development of logic models in their applicability and relevance.

- Act with caution about the possibility of challenges of working in a co-produced way, including funding, well-being, renumeration of service users and carers, time commitment and other unforeseen events (e.g. COVID-19).

- Choose appropriate digital technologies to maintain ongoing communication and collaboration and remove distance/remote working barriers.

- Include capacity within project budgets whereby the tight financial parameters and categories for the inclusion of all stakeholders are addressed to ensure that SU are involved throughput the process (commencing with the application process).

- For projects, which require translation include higher budgets for translations

Acknowledgement

We would like to thank Erasmus+ for funding this project. We are grateful for the continuous support and expertise given by service users, students, healthcare professionals and all members of national communities of practice. In particular, we would like to thank Dr Gary Lamph for his contribution during the initial stages of the project.

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The STRENCO Logic Model for Tripartite Working in Mental Health

STRENCO Vision: To support and enable more person-centred, co-produced, effective and safe mental health care and better health and wellbeing for people using mental health services. This can be achieved by service users and family members partnering with people who deliver health and social care services, educators and researchers using more collaborative/co-produced relationships. This requires the use of communication, collaboration, co-production, leadership, organisational and system approaches.

Context

Situation Analysis

Political and Legal

Policy
- EU frameworks
- EU Policies
- WHO frameworks
- Co-production strategy/policy
- National communities of practice (CoP) (knowledge, skills and experience)
- Low visibility or voice of service users in national policy.
- Mechanisms and capacity for service user (SU)/Family engagement limited by policy, health services and university procedures and finances

Legal
- Human Rights Legislation
- UN United Nations (UN) Convention on the Rights of Person with Disabilities.
- National Legislation

Economic
- Mental Health Services
- Lack of resources (staff, financial, infrastructure)
- Lack of knowledge and expertise transfer and training apart from mandatory options
- Increased demand for services
- Reduced investment on mental health research
- Lack of investment on peer-to-peer support and education
- Patient and Public Involvement (PPI) / SU Involvement
- Difficult to involve and reward service user involvement, move beyond tokenistic PPI

Social
- Ageing population
- Improve educational level of staff in primary care
- Early recognition of mental health problems in primary care
- Stigmatization of people with mental health problems
- Improve educational level to minimize stigmatisation and awareness about personal health
- Need for a new strategy/model of working whereby SU, family, practitioners and university can be integrated to enhance and develop the environment

Technological
- Varied quality of digital infrastructure (software and hardware) to ensure flow of information and communication
- Lack of focus on holistic and tailored digital solutions

Process

Inputs

Knowledge
- National CoP (knowledge, skills and experience)
- Frameworks for SU involvement
- Tools and resource documents

Key stakeholders and partners
- Health and social care professionals
- Colleges and academic institutions
- Service user advocacy groups
- Experts through experience
- International colleagues
- Communities of practice
- Technicians/Technical Assistance

Infrastructure / equipment
- Website
- University Learning Management Systems
- E-learning materials
- Communities of practice
- Used user-friendly internal and external communication systems (e.g. SLACK, MS SharePoint, MS Teams)

Finances
- Funding

Activities

Exploration/Investigation
- Explored concepts: co-production and collaboration and application to mental health
- Explored ways of collaboration in MH in EU partner countries
- Explored the use of gamification and e-learning in mental health

Practice
- Facilitated Intensive programmes (IP) with all stakeholder involvement
- Facilitated partnerships within CoPs in Mental Health in each EU partner
- Facilitated coproduction and testing of resources (through engagement with service users and health service SU executives)
- Commissioned coproduction and provided learning and development opportunities (through external agencies)
- Project planning
  - Established a communications strategy to raise awareness and co-ordinate information sharing
  - Created governance structures, systems and processes for running projects (e.g. steering committee, project meetings)

Reflection
- Participant reflections on actions

Outputs

Education, learning and support
- Developed a suite of accessible and user-friendly resources and tools, making use of service user, family, university and practice experience and knowledge
- Developed a suite of online materials to support learning
- Developed a competency framework for integration into curricula and policy
- Mapped evidence on content of co-production and collaboration in mental health in the EU.
- Clarified mental health policies/competencies in different EU partner countries.
- Identification of EU mental health care pathways
- Translated documents
- Novel learning approaches (shift towards problem-based learning using gamification, simulation) for eLearning materials for mental health
- Enabled and supported 2 groups from services, voluntary organisations and universities through training days

Networks and connections
- Created connections and partnerships with people across the system
- Established national and international networks
- Established national communities of practice
- Created standardised norms and processes to support collaboration

Dissemination
- Conference outputs (national/international audiences)
- Awareness campaigns about initiatives and events (e.g. dissemination days)
- Making online evidence readily available (via project website)

Outcomes

Immediate (for STRENCO participants)

- Increased awareness, understanding and knowledge of mental health competencies and the importance of family involvement
- Increased understanding of different perspectives, cultures and attitudes
- Enhanced awareness of coproduction
- Improved engagement with co-produced competencies in mental health
- Developed awareness of various capabilities (gamification, simulation, language)
- Increased self-awareness
- Enhanced awareness of coproduced relationships and initiatives
- Improved engagement with co-produced competencies in mental health
- Developed understanding of the importance of teamworking
- Developed awareness of the importance of family involvement
- Produced and analysed information in a meaningful way

Potential outcomes (medium & long term)

People who use mental health services
- Better experience and greater involvement
- Improved outcomes in relationships and care
- Greater participation in services
- Improved trust in the mental healthcare system
- Development of mechanisms to generate/encourage/create capacity for peer involvement

People who deliver mental health services
- Improved MH competency and knowledge
- Increased capacity, capability and confidence to work in more co-produced ways
- Improved collaboration and working relationships between MDT and SU/family
- Provide opportunities to lead improvements and have greater engagement with SU/family
- Create integrated, self-supporting networks to enable more co-produced pathways (Ongoing CoP)
- Develop greater involvement/integration with the university, as creators of knowledge and disseminators of evidence for practice

Organisations responsible for mental health service delivery (frontline)
- Improved quality, safety and efficiency of services
- Embedding/establishment of the knowledge triangle encompassing the SU and family perspective in strategies for service development and in governance systems
- Intelligent use of information and peoples' voices
- A person centred culture of learning and improvement

Systems level of organisers mental health services delivery (policy formation)
- Greater connectivity and sharing of learning
- Sustained policy development for integration of peers
- Collective ownership for co-produced working
- Sustained leadership to create co-production within the healthcare arena
- Develop capacities for peer involvement/training of peers

Process Mechanisms

Co-production

- Collaboration
- Recognition
- Dialogue
- Listening
- Shared power
- Decision making
- Equality
- Flexibility
- Facilitation
- Reciprocity
- Peer support
- Ownership
- Accomplishment
- Innovation
- Motivation
- Culture change

Communities of Practice

- Negotiation / consensus
- Identity
- Relationships
- Engagement / Active participation

Challenges

- Financial implications
- Time commitment
- Distance/remote working
- SU remuneration
- Higher levels of involvement and integration of SU / family members
- Time
- Language

Funded by the Erasmus + program of the European Union