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The Potential and Reality for the Inclusion of Service Users in Social Work

Abstract

This chapter sets out to examine the potential and the reality for the inclusion of service users in social work services, social work education, and social work research.

It includes special reference to such work with the most vulnerable service users, for example certain people with mental health problems. The chapter will critically examine the theoretical framework, potential of, and reality for, the inclusion of service users in social work services, social work education, and social work research.

The discussion will critically analyse the rationale, challenges and opportunities of involving service users and carers in such areas using ideas around the ethics of social work as set out in the International Federation of Social Worker's (IFSW)/International Association of Schools of Social Work's (IASSW) Ethical Codes (2012) and their Definition of Social Work (2014) and further analyzed against S. Arnstein's "ladder of participation".

In examining how we can work towards the greatest level of participation in co-production, the chapter will use examples from projects carried out by the author.

Introduction

This chapter examines the potential and reality for the inclusion of service users in social work services, social work education, and social work research.

The chapter will include particular reference to work with the most vulnerable service users, for example certain people with mental health problems. It will critically examine the theoretical framework, and potential

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and reality for the inclusion of service users in social work services, social work education, and social work research.

The rationale, challenges and opportunities to involve service users and carers as full partners and co-producers in any work from its inception, based on shared decision-making and co-production from these perspectives, are critically evaluated, using ideas from the ethics of social work as set out in the International Federation of Social Worker's (IFSW) / International Association of Schools of Social Work's (IASSW) Ethical Codes (2012) and their Definition of Social Work (2014), and further analyzed against Sherry Arnstein's (1969) "ladder of participation".

Following our examination of these levels of empowerment, it will then examine how we can work towards the highest level of participation in co-production.

The chapter will use examples from projects carried out by the author:

1) the UK's National Institute for Health and Care Excellence (NIHCE) Guideline *Violence and Aggression: The short-term management of violent and physically threatening behaviour in mental health, health and community settings* (re inclusion of service users in social work services) (2015);
2) a research project to develop and evaluate a programme based on the Recovery approach in mental health work, the *Whole Life* project (re social work research***)*** ; and
3) The co-production of a European online Masters in Mental Health Recovery and Social Inclusion (2018);[1] regarding social work education.

The growing recognition of co-production

There is growing international recognition that areas of professional jurisdiction should be opened up to greater public scrutiny, debate and power-sharing (Dominelli, 2016; Plotnikov, 2016).

We will start by examining overall and overarching relevant key principles from the IFSW/IASSW *Definition of Social Work* (2014), and its *Statement of Ethical Principles* (2012). *The Definition of Social Work* (2014) states that:

> Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. It also states that…much of social work research and theory is co-constructed with service users in an interactive, dialogic process and therefore informed by specific practice environments.

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[1] See Programme website: http://www.herts.ac.uk/courses/mental-health-recovery-and-social-inclusion-online2 (accessed 18.03.2018).

The Statement of Ethical Principles (2012) gives a fuller account of what this means in practice, such as:

> Respecting the right to self-determination; [...] respect(ing) and promot(ing) people's right to make their own choices and decisions; Promoting the right to participation (for) the full involvement and participation of people using their services in ways that enable them to be empowered in all aspects of decisions and actions affecting their lives; and Social workers should focus on the strengths of all individuals, groups and communities and thus promote their empowerment.

We can see from this that the issue of full involvement and participation of service users and carers is a key component of human rights-based social work practice according to this statement, within an emphasis on defending people's human rights, and respecting self-determination. Again we see the emphasis on promoting the right to participation of service users and carers. There is the duty, then, it can be argued, for social workers to move towards the highest levels of empowerment, with duties and responsibilities in relation to the creation of the context where this can happen.

This is complicated for social work by the fact that social work is unique amongst professions, in that it looks to balance the rights of different people in the situation in terms of their vulnerabilities, and whose rights may take precedence over whose others' rights – so it is not a simple matter of just ensuring that the wishes and needs of a particular service user or carer has to be pursued fully without regard to the needs of others. Within the UK situation, this is most clearly evident in relation to issues of "safeguarding", where we know that too much of an emphasis on the rights of parents has on a small number of occasions meant that the abuse of the child from the abusers has not been given the primary focus, against the needs of the parents. So, in the IFSW Definition, there is recognition of the fact that the loyalty of social workers is often in the middle of conflicting interests, and that social workers function as both helpers and controllers.

The position in the UK

In the UK, drawing on the International definition, the professional registering body for social workers and social work qualifying programmes, the Health and Care Professions Council (HCPC), in terms of its *Standards of Proficiency for Social Workers in England* (2017) (that registered social workers have to abide by or risk being struck off), makes clear its view that in relation to these areas by stating:

> HCPC (2017)….. understand the need to promote the best interests of service users and carers at all times – (by ensuring that social workers are)
> – able to work with others to promote social justice, equality and inclusion;
> – able to use practice to challenge and address the impact of discrimination, disadvantage and oppression;

- able to support service users' and carers' rights to control their lives and make informed choices about the services they receive;
- able to work in partnership with others, including service users and carers, and those working in other agencies and roles recognise the contribution that service users' and carers' own resources and strengths can bring to social work.

Therefore, a key area of concern is how we empower service users, and this should lead us to ask what are the key factors in the best possible model for co-production?

There has been a great deal of attention paid in the health and social care field in England in relation to co-production and the key place of it in terms of delivery of services in recent years. So for example, the National Health Service (NHS) England (the main government body for setting policy overall for the NHS) Mental Health Taskforce (2016) *Five year forward view for mental health*, sets out how co-production is now acknowledged as key for mental health agencies: "Services must be designed in partnership with people who have mental health problems and with carers" (National Health Service Mental Health Taskforce, 2016: 20).

Again, the English government's National Institute for Health Research (the main government body for setting research policy and providing funding for research in the NHS) (2015), states that in their view, the most successful collaborations will be those where knowledge is shared in a mutual partnership between researchers, the public and health professionals.

Despite this supportive policy context, Josephine Ocloo and Rachel Matthews (2015) argue that progress to achieve greater involvement is patchy and slow and often concentrated at the lowest levels of involvement of the S. Arnstein (1969) ladder set out below. By this they mean that consultation is more often the norm, rather than collaboration, with some health and care professionals and organisations having not embraced the idea of partnership with service users and even feeling threatened by the notion of service users' active involvement – their power, they perceive, is challenged. They discuss how engaging professionals and service users as co-production partners is difficult and time-consuming. Years after introducing the construct of shared decision making, these principles they find are rarely employed in patient/clinician encounters in the health sector. However, they also emphasise that not all patients/service users have the desire or capacity to be active participants in co-production in the services.

Co-production- some key issues for care and health

Maren Batalden et al. (2015) argue that co-production enhances the empowerment of service users in the delivery of care. They note Elke Loeffler et al's (2013) views on several motives for this movement:

- Employing the expertise of service users and their networks;
- Enabling more differentiated services and more choice for service users;
- Increasing responsiveness to dynamic user need;
- Reducing waste and cost.

They state that co-production should aim to jointly produce services, and should build on what is there already in the relationships to strengthen this in terms of innovation and improvement.

They also argue that at its core, the purpose of any involvement activity should be to improve the health and care experience of services for patients/service users, and that of their relatives and carers as well as the wider public. Research suggests that co-production supports recovery in mental health (e.g. Slay, Stephens, 2013).

Michael Clark (2015) sets out how in mental health care concepts of co-production offer deep challenges to how mental health and illness, experiences of these, and approaches to support and care are conceptualised and approached.

Michael Clark defines co-production as a concept for and a critique of services, and a guide for action, with its roots in the 1970s civil rights and social action movement in the USA (Realpe, Wallace, 2010). Mental health services were seen to be failing to clearly acknowledge service users and their experiences in the delivery of services in general, and in their own treatments. The debate moving forward from activists, some of whom were mental health service users themselves, and with local agencies and government, led to greater involvement of service users in decisions about services.

One organisation, Think Local Act Personal (2015) in the UK, has defined co-production from the perspective of people involved in the process as:

> When you as an individual are involved as an equal partner in designing the support and services you receive. Co-production recognises that people who use social care services (and their families) have knowledge and experience that can be used to help make services better, not only for themselves but for other people who need social care (Think Local Act Personal, 2015).

Co-production, then, can be seen to be concerned with:

- Processes of connecting people and communication;
- Processes that are ongoing, rather than isolated events;
- Questions about knowledge – whose knowledge and what is valued and how is it evaluated and synthesized in to co-produced plans?
- Issues of power – what is the right balance of power in the various stages of the processes of co-production, and in particular, in relation to disadvantaged and oppressed groups?

- Concern about outcomes – who defines them, who delivers them, and how is accountability for this organised, and again, in particular, in relation to disadvantaged and oppressed groups?

These points then relate to issues about to what extent service users and carers are involved in setting any new policy or service based on co-production ideals, then operationalising these, and then being involved in the evaluation and development of them. So when we are looking at these issues, we start to think about the level of empowerment and involvement as measured by S. Arnstein's ladder (1969) and the other models deriving from this.

Applying these ideas to care services, a key feature of this is confidence being developed in service users and carers in challenging the culture in agencies and professionals' own personal and professional views which enable service users and carers to move on from being passive recipients of services directed at them by professionals and organisations. This does not mean though, that service users and carers have to be responsible for the quality of these developments – Catherine Needham and Sarah Carr (2009), for example, argue that at the same time co-production is empowering professional staff in front-line services to draw on their professional expertise and make decisions with the people they support.

The idea of co-production can be seen widely across health and social care in policy and the rhetoric of "no decision about me, without me" (Department of Health, 2010, 2012). It can also be seen in the concept of "shared decision-making", an approach that has a developing evidence-base in terms of its potential impact (e.g. Durand et al., 2014). It has been asserted that co-production has an important role to play in delivering cost-effective services (Stevens, 2008). Catherine Needham and Sarah Carr (2009) sounded a note of caution that co-production would not be able to address all of the challenges in social policy, suggesting a need for very clear definitions of and evidence for its effectiveness. Yet, the scope that co-production is said as potentially applying to all areas continues to be widened, including to commissioning (e.g. Think Local Act Personal, 2015).

So, co-production is gaining ground as a key dimension of public policy reform across the globe (Organisation for Economic Cooperation and Development, 2011); as a response to the democratic deficit inherent in the delivery of public services (Pestoff, 2006), and as a way forward to galvanise active citizenship (Department of Health, 2010).

Slay and Stevens (2013), in a report commissioned by MIND, a UK mental health charity, for the New Economics Foundation, Co-*production in Mental Health. A Literature Review,* defined co-production as:

> A relationship where professionals and citizens share power to plan and deliver support together, recognising that both partners have vital contributions to make in order to improve quality of life for people and communities (Slay, Stevens, 2013: 3).

Principles of co-production

Slay and Stevens see six principles as the foundation stones of co-production, as follows:

- Taking an assets-based approach: transforming the perception of people, so that they are seen not as passive recipients of services and burdens on the system, but as equal partners in designing and delivering services;
- Building on people's existing capabilities: altering the delivery model of public services from a deficit approach to one that provides opportunities to recognise and grow people's capabilities and actively support them to put these to use at an individual and community level;
- Reciprocity and mutuality: offering people a range of incentives to work in reciprocal relationships with professionals and with each other, where there are mutual responsibilities and expectations;
- Peer support networks: engaging peer and personal networks alongside professionals as the best way of transferring knowledge;
- Blurring distinctions: removing the distinction between professionals and recipients, and between producers and consumers of services, by reconfiguring the way services are developed and delivered;
- Facilitating rather than delivering: enabling public service agencies to become catalysts and facilitators rather than being the main providers themselves.

Most of the strongest examples of co-production, Slay and Stevens (2013) argue, have all of these principles embedded in their day to day activities, but some principles may feature more strongly than others. Criteria to judge the level of participation might be argued to be as follows (Slay, Stevens, 2013):

Doing to

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

Doing for

As the pathway progresses, it moves away from coercion towards shallow forms of involvement. There is greater participation, but still within parameters that are set by professionals. Here, services are often designed by professionals with good intent with the recipient's best interests in mind, but service user's involvement in the design and delivery of the services is constrained. Professionals might, for example, inform people that a change will be made to how a service is to be run, or they may even consult or engage them to see what they think about these changes. However, this is as far as it goes. People are invited to be heard, but not given power to make sure that their ideas or opinions shape decision-making.

Doing with

These most advanced stages of the pathway mark a deeper level of service user involvement that shifts power towards them, requiring a fundamental change in how service workers and professionals work with service users, recognising that positive outcomes cannot be delivered effectively to or for people, but can only truly be achieved with people, through equal and reciprocal relationships. Service users' voices must be heard, valued, debated, and then acted upon (and the results of all this fed back to the service users involved). This can take many forms, from peer support and mentoring to making decisions about how the organisation is managed/policies developed/reviewed. At this level, service users' assets and capabilities are recognised and nurtured, professionals and services users work together in equal ways, respecting and valuing each other's unique contributions.

So, in this model, understanding of co-production is informed by

- the presence of the six principles of co-production;
- how power is balanced between people getting support, and the professionals involved in co-production;
- in relation to social care it involves the insight that care services cannot be produced without input from the people who use services.

Co-production requires a culture that values service users and practitioners alike, and that this may be achieved through a broader adoption of relationship-centred approaches.

In examining how we can move towards co-production rather than just taking into account the views of service users about their services, we can make use of S. Arnstein's "ladder of participation" model (see below), which as part of its 8 rungs on the ladder goes from the bottom 2 rungs of the ladder – Manipulation and Therapy – to the 2 topmost rungs, Delegated Power and Citizen Control.

“Othering” of disadvantaged and oppressed groups

Adital Ben-Ari and Roni Strier (2010) argue that the French philosopher Emanuel Levinas’ conceptualisation of the “Other” (Levinas, 1969), based upon philosophical ideas of how we can claim to know the experiences and reality of others that may further label those other cultural/ethnic groups, challenges prevalent conceptions of cultural competence and examines the relationship between cultural competence, where social workers understand and positively respond to problematic areas in cultural differences, and the “Other”, especially where they are from disadvantaged and oppressed groups. Cultural competence means having the ability to appreciate the experiences of, communicate and work effectively with, people from different cultures. It can be argued that in order to work well with differences, a comprehensive understanding of the relations between “Self” and the “Other” is necessary (Ben-Ari, Strier, 2010; Park, 2005). Adital Ben-Ari and Roni Strier state that social work must recognise it needs to respond effectively to people of all different cultures, ethnic backgrounds, religions, social classes and “Other” diversity factors in a manner that recognises and values the worth of individuals, families and communities and protects and preserves their dignity (Littlechild, 2012).

One example of the issues involved in, and responses to, the identification and development of cultural understandings is that of child protection work the United Kingdom, which has a lengthy history of migration and movement of people. When families move countries they bring with them their own traditions and customs, their religious faiths and child-rearing of children. Adjusting to new traditions and child rearing “norms” creates difficulties for families and this is something social workers need to develop an awareness of and sensitivity to. For the families, however, these experiences are often tainted by discrimination in the UK, and at times open hostility, and the fact that often they do not have a readily available, or culturally acceptable, network of support to draw on, and/or they may be dislocated from community and cultural networks. Many migrants experience a sense of loss for the country they have left. There are also the effects of migration from the longer history of such movements for families, children and young people; for example for second, third generation and other previous former immigrant families, even if those families have been settled in the UK for many generations. Children who have been socialised in the United Kingdom within, for example, the school system may potentially find this causes cultural strains with family, friends and social structures (Simpson, Littlechild, 2009).

It has been argued that co-production provides a means to overcome the “othering” involved in much service delivery, allowing service users to (re)discover a sense of agency and opportunity to act on and change their own situations within the wider world (New Economics Foundation, 2013).

The place of “agency” is key to reinstating marginalised people as citizens; Pierre Bourdieu (1984) views the most damaging forms of social suffering as those experienced by people “on the margins”: those who have reduced access to empathy, respect and social recognition – this is also a theme which has been taken up in an extensive literature (see e.g. Frost, Hoggett, 2008).

Models of co-production

One of the most frequently referenced and utilised models of levels of co-production derives from work in public planning in the USA in terms of S. Arnstein’s ladder of participation (Arnstein, 1969), but also applicable to all service users.

At the highest rung on the ladder, experts by experience lead from the outset-followed by, in descending order of levels of participation:

- Equal partnerships between staff and experts by experience from the outset;
- Experts by experience included once main area of the policy practice is determined;
- Experts by experience are consulted about the main areas of work, but not included in key decision-making discussions/reviews;
- “Lip service” is given to the inclusion of experts by experience and are only informed of key decisions;
- Manipulation of experts by experience solely to give the impression that experts by experience co-production has taken place (Arnstein, 1969).

Debates continue to range across what are the most appropriate levels of involvement, the best mechanisms for achieving these and the outcomes from that involvement. The National Institute for Health Research School for Social Care Research, for example, has published a scoping paper by Beresford and Croft (2012) in which the authors argue for more user-controlled research.

Josephine Ocloo and Rachel Matthews (2015), as mentioned above, argue that at its core, the purpose of any involvement activity should be to improve the health and the experience of services for patients, their relatives, and carers. Schema 2 below provides a typical organising framework for involvement (the term engagement is used in this framework) that shows involvement can take place at multiple levels.

Schema 1. A multidimensional framework for patient and family engagement in health and healthcare

Continuum of Engagement: →

Levels of engagement → ↓	**Consultation →** ↓	**Involvement→** ↓	**Partnership and shared Leadership** ↓
Direct care	Patients receive information about a diagnosis	Patients are asked about their preferences in treatment plan	Treatment decisions are made based on patients' preferences, medical evidence, and clinical judgment
Organisational design and governance	Organisation surveys patients about their care experiences	Hospital involves patients as advisers or as advisory council members	Patients co-lead hospital and quality improvement committees
Policy making	Public agency conducts focus groups with patients to ask opinions about a Health Care issue	Patients' recommendations about research priorities are used by public agencies to make funding decisions	Patients have equal representation on agency committee that makes decisions about how to allocate resources to health programmes

↕ ↕ ↕ ↕

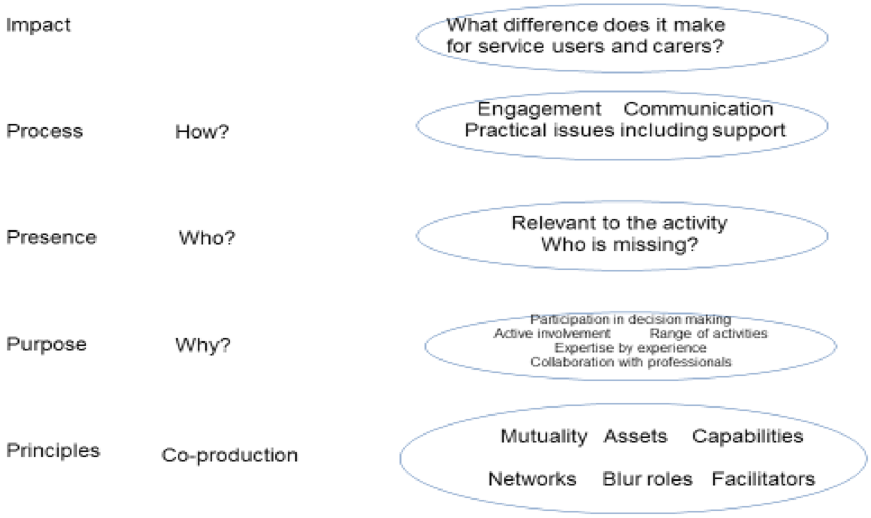
Factors influencing engagement:
Patients (beliefs about patient role, health literacy, education)
Organisation (policies and practice, culture)
Society (social norms, regulations, policy)

Source: Reproduced in Ocloo and Matthews (2015) with permission of Project HOPE/Health Affairs from Carman et al. (2013)

It can range along a continuum, from consultation to partnership and shared leadership. At the lower end, patients are involved but have limited power or decision-making authority. At the higher end, involvement is characterised by shared power and responsibility, with patients/service users as active partners in defining agendas and making decisions. Service user involvement can occur at the level of individual health behaviour or direct care, or at the collective level in organisational design and governance and in policymaking. Other areas can include commissioning, monitoring, evaluation and research. Multiple factors can affect the willingness and ability of patients to engage at these different levels, including patient beliefs about their role, health and care literacy, education, organisational policies and practices and culture, society and social norms, regulation and policy. Josephine Ocloo and Rachel Matthews (2015) believe that issues to do with inequality, discrimination and social exclusion also play a strong role in preventing many individuals and groups participating in the involvement process as indicated in schema 2 below. This schema builds upon S. Arnstein's widely quoted "ladder of citizen participation" referred to above, describing "a continuum of public participation in governance ranging from limited participation, or degrees of tokenism, to a state of collaborative partnership in which citizens share leadership or control decisions".

Littlechild and Machin (2016), in a presentation entitled to the McPin Foundation's conference on 30 November 2016, *Collaborating with people with lived experience public involvement: research methods*, reflected on "going the extra mile in mental health research on co-production", and suggested that we should measure participation and co-production against the following model:

Schema 2. Model of involvement



Source: Presented in paper to conference (Littlechild, Machin, 2016)

Giving examples from the presenters' own projects and research areas within the mental health field, B. Littlechild and K. Machin set out:

- The practice-based Whole Life Project, where the research team of service user researchers, agency staff, and university-based staff co-constructed a Whole Life Programme that acted as a therapeutic instrument to be used between a coach (professional), and a participant (service user), which was then evaluated by the research team of service user researchers, agency staff, and university-based staff, leading to the co-construction of the findings in the final report and in a journal article (Littlechild et al., 2013).
- The development and outcomes of an innovative online European Union funded online Master in Mental Health Recovery and Social Inclusion, developed by both agency staff and service users, and with staff and service users as students on all its 5 cohorts to date (Erasmus+ Europe Union, 2015);
- The UK National Institute for Health and Care Excellence (NIHCE, 2015) *Guideline on dealing with Violence in Mental Health work*, addressed one of the most challenging of areas for such co-production, of working positively and jointly with service users, staff and carers in addressing the causes, consequences and resolution of issues from when there is violence from mental health service users on staff, themselves, and others in their formal and informal networks. The Guideline covers how best to respond to staff, service users and others after such incidents, and the potential for jointly produced solutions to the issues that arise, as part of the construction of the NIHCE Guideline on *Violence and Aggression: The short-term management of violent and physically threatening behaviour in mental health, health and community settings* that took place with service users and carers. Of particular note for our current purposes is its inclusion of one key recommendation, on developing service user-led monitoring units in agencies to review and make changes to services after such incidents, a recommendation being piloted in 2017 in a project by the current author.

Examples from New Economics Foundation (2013) of co-produced services

This New Economics Foundation study of co-produced services commended one particular project in this area – the Croydon Service User Network (SUN), which has been explicitly co-designed by professionals and service users. SUN members participate in the running of the service, feedback their opinions, represent the groups at the SUN Steering Group and work alongside staff to help in the running of the groups. This ongoing connection between service users and professionals allows for a blurring of roles, and for building greater trust and a sense of shared endeavour. All members are making a valuable contribution, either in running the network, in organising group meetings, or by providing direct support to other members. The involvement of professionals as partners in the group means an active relationship is maintained, creating opportunities to influence professional practice and draw on professional mainstream professional practice, but opportunities for collaboration and influence are considerable in comparison with other examples. One aspect of this is that professional allies are funding research and evaluation of the impact of SUN as an intervention. They are in a position to use this information to influence their own professional peers, perhaps more effectively than service users can on their own.

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

Service user participation/co-production in practice: a guide to action

We will now look at what may be the barriers for co-production, and then what practical steps can be taken to facilitate its implementation in social work (based on Ocloo, Rachel, 2015).

Barriers to co-production:

- *Equality and discrimination*: barriers on the basis of gender, ethnicity, culture, belief sexuality, age, disability and class, from individuals/agencies/policies.
- *Where people live*: Homelessness, being in residential services, or the prison and the penal system. Travellers/gypsies.

- *Communication issues*: people with hearing disabilities. Blind/ visually impaired people. People who cannot communicate verbally. People for whom English is not their first language.
- *Unwanted voices*: Some points of views/ experiences are more welcome than others (particularly those who agree or are less challenging of the system or services). People can also be excluded because they are seen as too expensive/difficult to include, such as those with dementia.
- *Devaluing people*: not valuing or listening to what people say.
- *Tokenism*: asking for involvement but not taking it seriously or enabling it to be effective.
- *Stigma*: stigmatising people for their identity or why they became involved or because they have had a poor experience of care and discouraging involvement on the basis of their identity. (*Current author: and also negative discrimination towards disadvantaged and oppressed groups, I would argue*).
- *Confidence and self-esteem*: making people feel they do not have much to contribute.
- *Inadequate information about involvement*: Lack of appropriate and accessible information about getting involved or about the involvement opportunities.
- *Gatekeepers/individuals who block the involvement process*: individuals who obstruct the involvement process by their attitudes or actions and stop people getting involved.
- *Financial barriers*: not paying participants for their involvement (which is a widely accepted principle) and speedily can deter people with limited resources or high costs because of the nature of their situation or impairment from being involved.
- *Access*: ensuring all participants have effective ways into organisations and decision-making structures to have a real say in them.
- *Support*: building confidence/skills, offering practical help/ opportunities to get together to support people's empowerment and capacity.
- *Use of advocacy*: important for people who are disempowered and/ or isolated.
- *Different forms of involvement*: using innovative approaches that go beyond traditional methods; meetings, surveys, written and verbal skills.
- *Outreach and development work*: reaching out to those traditionally identified as 'hard to reach', going to them and community leaders, building trust, asking what works.

- *Meetings where used*: making them attractive, inclusive, enjoyable, with free refreshments that are culturally appropriate, safe, supportive environment, with access to key knowledge.
- *Good practice regarding health literacy*: Improving communication with all patients can include: ascertaining what the patient knows, first to determine level of discussion. Speaking slowly, avoiding jargon, repeating points to improve comprehension, encourage and expect all patients to ask questions.
- *Communicate*: In ways other than speech/printed material, e.g., multimedia, translation services/materials.

So, from consideration of all of these areas, the overarching principles of service user participation/co-production can be seen to be:

- The service user experiences feelings of respect from the agency statements and procedures, and the staff's attitudes, methods and skills;
- The person experiences that they are listened to, and valued for themselves, not because they are participating to meet agency/worker performance indicators;
- The physical settings, timings of meetings/consultations are appropriate for them;
- Processes feel inclusive, welcoming and valuing of them;
- The person has feedback on how participation results are used/affects their future;
- Groups of service users have feedback on how participation results are used;
- They have access to trusted supporters, and have careful and sensitive preparation for the whole participation process;
- Staff are able to think themselves into the position of the person to appreciate their concerns/anxieties about the process and possible outcomes, and demonstrate this to them;
- Check with them what you have understood the group/person has said to you;
- If research, go back with the findings/recommendations with the person/group;
- The person has confidence in how issues of confidentiality/control of the views/information afforded will be determined/used;
- Move at the peoples' own pace;
- Ready access to knowledge about procedures, and how to get support to make use of them; This is a particular problem for service users in need because of abuse or neglect, due to their access to trusted adults outside their family network, and fear of reporting abuse.

The issues then are:

How can we align these issues/models with the IFSW Standards to gain the highest level of co-production with the most disadvantaged/unfairly discriminated against/antagonistic/least confident service users and carers?

How might models for involving people with service user lived experience in social work services evolve? Based on what models and criteria?

To what extent do we attempt to/successfully manage to engage with the disadvantaged/disengaged/antagonistic individuals and groups?

These then become key questions for social work and social workers in fulfilling social work's values of service user and carer empowerment, involvement, and social justice.

References

Arnstein S. (1969), *A ladder of citizen participation*, "JAIP", vol. 35, no. 4, pp. 216–224.

Anthony W.A. (1993), *Recovery from mental illness: The guiding vision of the mental health service system in the 1990s*. "Psychosocial Rehabilitation Journal", vol. 16, pp. 521–538.

Batalden M., Batalden P., Margolis P., Seid M., Armstrong G., Opipari-Arrigan L., Hans Hartung H. (2015), *Co-production of healthcare service*, available at: http://qualitysafety.bmj.com/content/early/2015/09/16/bmjqs-2015-004315 (accessed: 18.03.2018).

Bee P., Price O., Baker J., Lovell K. (2015), *Systematic synthesis of barriers and facilitators to service user-led care planning*, "The British Journal of Psychiatry", vol. 207, pp. 104–114, doi: 10.1192/bjp.bp.114.152447.

Ben-Ari A., Strier R. (2010), *Rethinking Cultural Competence: What Can We Learn from Levinas?*, "British Journal of Social Work", vol. 40, no. 7, pp. 2155–2167.

Beresford P., Croft S. (2012), *User controlled research. London: NIHR School for Social Care Research*, available at: http://www.sscr.nihr.ac.uk/PDF/ScopingReviews/SSCRScopingReview_5_web.pdf (accessed: 24.07.2015).

Bourdieu P. (1984), *Distinction: A Social Critique of the Judgment of Taste*, Routledge, London.

Boyle D., Slay J., Stephens L. (2010), *Public services inside out*, New Economics Foundation and NESTA, London.

Cahn E. (2000), *No more throw away people: the co-production imperative*, Essential Books, Washington.

Carman K.L., Dardess P., Maurer M., Sofaer S., Adams K., Bechtel C., Sweeney J. (2013), *Patient and family engagement: a framework for understanding the elements and developing interventions and policies*, Health Aff, Millwood, vol. 32, p. 223–231, available at: https://www.ncbi.nlm.nih.gov/pubmed/23381514 (accessed: 23.05.2018).

Clark M. (2011), *Mental health care clusters and payment by results: considerations for social inclusion and recovery*, "Mental Health and Social Inclusion", vol. 15, no. 2, pp. 71–77.

Clark M. (2015), *Co-production in mental health care*, "Mental Health Review Journal", vol. 20, no. 4, available at: https://www.emeraldinsight.com/doi/abs/10.1108/MHRJ-10-2015-0030 (accessed: 18.03.2018).

Department of Health (2010), *Practical Approaches to Co-production*, DH, London.

Department of Health (2011), *No health without mental health*, DH, London.

Department of Health (2012), *Liberating the NHS: no decision about me, without me. Government response*, DH, London.

Dominelli L. (2016), *Citizenship and voluntarism: A meaningful combination or the basis for exploitative relationships?*, "Foundations of Science", vol. 21, no. 2, pp. 385–397.

Durand M.A., Carpenter L., Dolan H., Bravo P., Mann M., Bunn F., Elwyn G. (2014), *Do interventions designed to support shared decision-making reduce health inequalities? A systematic review and meta-analysis*, "PubMed PlosOne", available at: https://www.ncbi.nlm.nih.gov/pubmed/24736389 (accessed: 18.03.2018).

ERASMUS + Europe Union (2015), *Success Story/Good Practice example*, available at: http://ec.europa.eu/programmes/erasmus-plus/projects/eplus-project-details-page/?nodeRef=workspace://SpacesStore/df58e9b7-d60f-45c8-9326-ee5ffce17029 (accessed: 23.05.2018); http://www.herts.ac.uk/courses/mental-health-recovery-and-social-inclusion-online2 (accessed: 18.03.2018).

Masters in Mental Health Recovery and Social Inclusion (2018), available at: http://www.herts.ac.uk/courses/mental-health-recovery-and-social-inclusion-online2 (accessed: 18.03.2018).

Frost L., Hoggett P. (2008), *Human agency and social suffering*, "Critical Social Policy", vol. 28, no. 4, pp. 438–460.

The Health and Care Professions Council Standards of Proficiency for Social Workers in England (HCPC) (2017), available at: http://www.hpc-uk.org/assets/documents/10003B08Standardsofproficiency-SocialworkersinEngland.pdf (accessed: 18.03.2018).

International Federation of Social Worker's / International Association of Schools of Social Work Ethical Codes (2012), available at: http://ifsw.org/policies/statement-of-ethical-principles/) (accessed: 18.03.2018).

International Federation of Social Worker's / International Association of Schools of Social Work Ethical Codes (2014), available at: http://ifsw.org/get-involved/global-definition-of-social-work/ (accessed: 18.03.2018).

INVOLVE (2012), *Briefing notes for researchers: involving the public in NHS, public health and social care research*, INVOLVE, Eastleigh.

Le Boutillier C., Leamy M., Bird V.J., Davidson L., Williams J., Slade M. (2011), *What Does Recovery Mean in Practice? A Qualitative Analysis of International Recovery-Oriented Practice Guidance*, "Psychiatric Services", vol. 62, no. 12, pp. 1470–1476 (DOI: 10.1176/appi.ps.001312011) (accessed: 23.05.2018).

Levinas E. (1969), *Totality and Infinity: An Essay an Exteriority*, PA, Duquesne University Press, Pittsburgh.

Littlechild B. (2012), *Values and cultural issues in social work*, "ERIS web journal", vol. 1, available at: http://periodika.osu.cz/eris/dok/2012-01/07_values_and_cultural_issues_in_sw.pdf (accessed: 18.03.2018).

Littlechild B., Machin K. (2016), *Going the Extra Mile in Mental Health Research: Reflections on Involvements at the University of Hertfordshire*, conference presentation at 'Collaborating with people with lived experience public involvement: research methods', available at: http://mcpin.org/mcpin-methods/ (accessed: 10.03.2018).

Littlechild B., Woodward J., Smith A. H., Meredith-Windle G., Gale G., Lloyd M., Hawley C. (2013), *Recovery approaches in mental health: A qualitative evaluation of the Whole Life Therapy programme for persons with schizophrenia*, Health, DOI: 10.4236/health.2013.53A077:582-587 (open access), available at: http://www.scirp.org/journal/PaperInformation.aspx?PaperID=52786#.VKNhfMnQrzE (accessed 18.03.2018).

Loeffler E., Power G., Bovaird T., Hine-Hughes F. (eds.), (2013), *Co-production of health and wellbeing in Scotland*, UK: Governance International, Birmingham.

National Health Service (NHS) England Mental Health Taskforce (2016), *Five year forward view for mental health*, NHS England, London.

National Institute for Health Research (NIHR) (2015), *Going the Extra Mile*, NIHR, London, available at: https://www.nihr.ac.uk/news/going-the-extra-mile-a-strategic-review-of-public-involvement-in-the-national-institute-for-health-research/2739 (accessed 23.05.2018).

National Institute for Health and Care Excellence (NICE) (2015), *Violence and Aggression: The short-term management of violent and physically threatening behaviour in mental health, health and community settings*, NICE, England, available at: https://www.nice.org.uk/guidance/ng10 (accessed 15.05.2018).

Needham C., Carr S. (2009), *SCIE Research briefing 31: co-production: an emerging evidence base for adult social care transformation,* Social Care Institute for Excellence, London.

New Economics Foundation (NEF) (2013), This Together Building knowledge about co-production, New Economics Foundation (NEF), available at: http://www.cnwl.nhs.uk/wp-content/uploads/2013/01/In_This_Together.pdf (accessed: 18.03.2018).

Ocloo J., Matthews R. (2015), *From tokenism to empowerment: progressing patient and public involvement in healthcare improvement*, available at: http://qualitysafety.bmj.com/content/25/8/626 (accessed: 18.03.2018).

Organisation for Economic Cooperation and Development (OECD) (2011), *Together for Better Public Services: Partnering with Citizens and Civil Society*, OECD, Paris.

Park Y. (2005), *Culture as deficit: A critical discourse analysis in contemporary social work discourse*, "Journal of Sociology and Social Welfare", vol. 32, pp. 11–33.

Pestoff V. (2006), *Citizens and co-production of welfare services*, "Public Management Review", vol. 8, no. 4, pp. 503–509.

Plotnikov M. (2016), *Letting go of managing? Struggles over managerial roles in collaborative governance*, "Nordic Journal of Working Life Studies", vol. 6, pp. 109–128.

Realpe A., Wallace L. M. (2010), *What is co-production?*, The Health Foundation, London.

Simpson G., Littlechild B. (2009), *International aspects of social work with children, young people and families*, [in:] S. Lawrence, K. Lyons, G. Simpson, N. Huegler, (eds.), *Introducing International Social Work*, Learning Matters, Exeter.

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

Stevens L. (2008), *Joining the Dots: How all the system elements can connect to drive personalisation and co-production, incorporating individual social and community capacity*, New Economics Foundation, London.

Tambuyzer E., Pieters G., Van Audenhove C. (2014), *Patient involvement in mental health care: one size does not fit all: Patient involvement in mental health care*, "Health Expectations", vol. 17, no. 1, pp. 138–150.

Think Local Act Personal (2015), available at: http://www.thinklocalactpersonal.org.uk/Browse/Informationandadvice/CareandSupportJargonBuster/#Co-production/ (accessed: 23.05.2018).

Thomas S., Wallcraft J. (2004), *Involving the Public in NHS, Public Health and Social Care Research: Briefing Notes for Researchers*, 2nd ed., INVOLVE, Hampshire.

Tse S., Tang J., Kan A. (2015), *Patient involvement in mental health care: culture, communication and caution*, "Health Expectations", vol. 18, no. 1, pp. 3–7.

Websites

http://ec.europa.eu/programmes/erasmus-plus/projects/eplus-project-details-page/?nodeRef=workspace://SpacesStore/df58e9b7-d60f-45c8-9326-ee5ffce17029