Working towards Co-production in Rehabilitation and Recovery Services

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Abstract

Purpose

This paper outlines the work of a service provider, service user and carer group created to develop a strategy for service user and carer co-production.

Approach

A reflective narrative account is given of the process through which the group formed and began to develop a working model aimed at shaping a cultural shift towards more co-produced services. The paper has been co-produced and includes the collaborative voices of service users, carers, multi-disciplinary staff, third sector representatives, managers and colleagues from associated services.

Findings

The model developed outlines 3 stages for services to work through in order to achieve meaningful and sustainable co-produced services. The importance of developing associated policies related to such areas as recruitment, payment, support and training is also outlined. Challenges to co-production are noted along with suggested approaches to overcoming these.

Implications and Value

The ethos of co-production is relatively new in the UK and so knowledge of the process and model may help guide others undertaking similar work.

Key words: Co-production, service user involvement, rehabilitation, inclusion, service development, service culture change

Article classification: Case study

Working towards Co-production in Rehabilitation and Recovery Services

Introduction

Over the last decade, there has been a move away from pathology and towards optimizing wellbeing; with an emphasis on principles of recovery within mental health services in the UK. This has come hand in hand with the realization that people with mental health problems and the family and friends who help support them are themselves experts in what it is like to live with these conditions, and it is this 'lived experience' that should be central in guiding the way our services are shaped. The values and ethos for this have been emphasized and targets to aim for have been highlighted in several published UK guidelines (From No Health Without Mental Health: A Cross Government Mental Health Outcomes Strategy for People of All Ages, Her Majesty's Government/Department of Health, 2011, to Closing the Gap: Priorities for essential Change in Mental Health, Social Care, Local Government and Care Partnership Directorate, 2014, to Welsh guidance in the form of the Mental Health Measure, 2010, the Welsh Assembly Government's Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales, 2010 and the Stronger in Partnership Documents 1 and 2; Welsh Assembly Government, 2001 and 2008 respectively, the 2010 Guidance on Involving Adult NHS Service Users and Carers and the National Principles for Public Engagement in Wales, 2011; NHS Wales). The UK is not alone in focusing on such 'joint working' as evidenced in publications such as The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (Mental Health Commission of Western Australia, 2014) and "If you want to go fast, walk alone. If you want to go far, walk together": Citizens and the co-production of public services (Löffler, Parrado, Bovaird and van Ryzin, 2008). 'Wellbeing', 'involvement' and the importance of 'lived experience' can therefore now be seen as being firmly on the agenda within mental health services across the UK and beyond. However, there still remains for local mental health providers and services within them to identify strategies & policies for putting these guidelines into practice. Whilst there are undoubtedly pockets of good practice, and a desire to build on these, there is a need to develop inclusive, robust and consistent processes to ensure appropriate and optimal Service User[1] and Carer[2] Involvement across local areas. This

[1] Multiple alternative terms exist, such as client, patient , survivor, or expert by experience but for the purposes of this document the term Service User will be used for ease of recognition and reference

paper provides a reflective, narrative account of working towards co-production within an established Rehabilitation and Recovery Inpatient Service.

The inpatient component of the rehabilitation and recovery services (R&R) within Abertawe Bro Morgannwg University Health Board (ABMU) consist of five units across three boroughs in South Wales. These are; a newly built low secure service for men (two ward areas of 14 beds each in a stand-alone building), a locked rehabilitation unit for men and women (18 beds), a mixed gender open rehabilitation unit (18 beds) and two step down houses that provide a bridge between inpatient and community living (8 beds). In addition the service currently includes some community provision (Criminal Justice and Liaison Team, Adult Community Forensic Team, Community Rehabilitation Team) and Prison Inreach. Service Users may progress through these services in a step down fashion, be repatriated from the private sector or be referred in from acute services depending on levels of risk and need. Each service then focuses on helping individuals to move on towards more independent living through developing living skills, confidence and coping strategies over time.

The R&R service has a strong recovery ethos (e.g. Davies, Maggs & Lewis, 2010) and has a history of development and innovation including the development of treatment programmes (e.g. Nagi & Davies, 2014) developing family involvement in low secure care (Nagi & Davies, 2015) and family liaison meetings in open rehabilitation (Davies, 2014 unpublished) and utilizing community resources to support and foster inclusion (Roberts, Davies & Maggs, 2015). These services have undergone significant redevelopment over the last two years; this process has caused us to reflect on our core values and recalibrate our "working compass". As we have done this, we have begun to realise that our aspirations are for co-production[3] rather than simply involvement; we feel that it is only by truly working in partnership on an equal footing with those who use our services, that we can rise above tokenism to ensure that 'involvement' becomes truly meaningful. However, it was only as we started to look around us

[2] Family members or friends may not always consider themselves to be 'Carers', however this term is again used for ease of reference to refer to those individuals who provide informal care, help or support to those who use services

[3] "A way of working whereby...people who use services, family carers and service providers work together to create a decision or service which works for them all. The approach is value driven and built on the principle that those who use a service are best placed to help design it" (pp3 NEF, 2013).

to attempt to identify and make links with local people and resources for guidance and support that we realised that R&R was not alone in often feeling that we are a long way off from our aspirations. Early support from colleagues in the third sector[4] helped us to realise that whilst it would be possible to just get on and 'do' co-production in some areas of service delivery (e.g. inviting service users to help interview for staff recruitment). This would be somewhat missing the point if we did not have an established system in place to support the development of these processes and the shift in culture this would require. For instance, involving service users in developing the recruitment process raises key questions such as "how would power imbalances be identified and managed within the panel?", "what support and training would be available for those involved?". From these early meanderings, we began to build a working group of like minded individuals; representatives from each unit across R&R, each discipline, service users and carers with experience of R&R (some current, others more historical), and individuals from the third sector with service user and carer engagement roles. We also made links with those involved in volunteer recruitment processes across the health board, the finance department, local NHS training courses with service user involvement components and those responsible for facilitating involvement processes across the wider health board.

For the last 18 months, we have been therefore been working together on a service user and carer co-production strategy for rehabilitation services within ABMU. As one member of our group put it; "*It feels like we have moved mountains, but still have Everest to climb*". Nonetheless, it seems we are at a useful vantage point from which to step back, see how far we have come and admire the view. As we have been and still are scaling the mountain as a team, it also seemed appropriate to write about it as a team. We considered the option of each person writing a section from their own perspective; but to us that seemed to have the potential to segregate individuals into 'us' and 'them'; rather than allowing us to write from the truly co-produced perspective we have been working towards. We have therefore spent time reflecting on our experiences as a group, and so this article will attempt to outline the perspectives of all those who contributed, giving each voice equal weight (and in easily accessible language) - including that of those who may not have regularly attended meetings,

[4] The third sector comprises organisations such as businesses and charities who are not-for-profit entities.

but have nonetheless helped support, shape or reflect upon our work. We developed a set of questions to guide our reflections and so will outline the perspective of group members based, in part, on answers to these.

What have we been working towards and why?

It is our experience that individuals who use Rehabilitation and Recovery services and their families have often, by the point that admission to such services occurs, been on an emotional rollercoaster which has left them feeling exhausted, burnt out, disillusioned and wary of any further support that is offered. The very challenge within these services then parallels that of Arnstein's ladder of citizen engagement (1969;often used to illustrate the aims of co-production); one of moving from a relationship of 'doing to' people, past one of 'doing for' onto one of 'doing with'. The goal is for individuals to regain the sense of power and control needed for increased independence. For this reason then, rehabilitation and co-production can be seen as needing to go hand in hand. In the words of our groups members: "*It makes good sense that if services are more in line with what service users want and need this should hopefully, ultimately, ensure that services are better and encourage/facilitate recovery*." In addition, it was noted that "*People get better quicker if they are positive about their condition. In mental health we disable people who are subject to the Mental Health Act by relieving them of many rights and responsibilities and freedoms of choice*". Thus, a large part of the way forward within this then is about "*challenging the medical model of the professionals being the expert and the service user being the passive recipient of services. So it is shifting the power and responsibility of recovery.*" These ideas are supported by findings in the literature (e.g. Petersen, Hounsgaard and Nielsen, 2008).

Nonetheless, it would seem that despite pockets of good practice, a proportion of current services remain largely at the 'doing to' or doing for' end of Arnstein's ladder Within our wider service, this has been evidenced by a series of (as yet unpublished) focus groups and surveys carried out by our strategy group across the five rehabilitation units. Challenges with achieving co-production within these units were identified as (amongst other things) difficulties in engaging service users (often due to the nature and extent of their mental health difficulties), lack of knowledge, skills, time, resources and confidence (often for service users, carers and staff) and also more generally the huge shift in culture that would be required. Conduct-

ing these evaluations was helpful in establishing a baseline against which to measure future change and also to begin to create a profile of each unit to allow interventions and approach to be tailored. However, the focus of this article is on the process by which these were developed and the model for moving forward that arose from this. It is hoped this will be the start of a series of articles related to the work of our strategy group.

Setting up base camp and building our team

Each of us can remember, in our own way, how overwhelming it was just getting started. We will stick with the mountain climbing analogy for now and say it was like meeting those who were to be our fellow mountaineers for the first time – realizing we had a long journey ahead, but not really being quite sure what it would entail. For some the first meeting was "*absolutely nerve-racking*"; no-one knew what to expect and it was hard to remember people's names and what their role was. For some there was recognizing faces from other settings; (*'Should I mention that I remember you as a client/ therapist*?' and '*seeing all the professionals that got me better')* and having to navigate new kinds of relationships with different boundaries. This was a process of constantly checking things out with each other and learning along the way – '*How should I approach this, how was that, would you like me to do anything differently?'*.

An excellent guide to involving adult Service Users and Carers (Husband, Carr and Jepson, 2010) emphasizes the importance of keeping the '4 Rs of working together' clearly in focus throughout all work in order to minimize potential difficulties. These 4 'R's' are Role (i.e. clarity of this), Remit (having a clear purpose), Relationships (working as a team) and Responsibility (clear terms of reference and accountability). Local guidance from Stronger in Partnership 2 (Welsh Assembly Government, 2008) also outlines four necessary pre-requisites for meaningful involvement:

- Building of confidence – helping Service Users and Carers build confidence in the role through using their strengths as 'experts' in their own experiences
- Providing timely and relevant information
- Providing a suitable space and time – this may include service providers going directly to Service Users and Carers rather than expecting them to travel to

professional meetings

- Receiving feedback and responding appropriately; including showing how views have been acted upon or explaining the reasons if they have not

We therefore attempted to hold these principles in mind as we selected our venue, and recruited people to join. We set ourselves a target of one year to develop a local strategy; our map for climbing the mountain. At the time, this seemed generous but looking back now 18 months on we realise how much time it truly takes. At least the first 6 months or more were spent identifying and building our membership and creating the terms of reference document to make sure we were all clear about what we wanted to do. Involvement from the third sector was really key; it was useful to have critical friends who brought their own set of skills and knowledge to help shape our journey. It was also essential to have the support and encouragement of senior managers both within and outside of R&R. This fostered a 'can do' attitude to helping us navigate issues as they arose (such as finding resolutions to the issue of appropriate payment). It also placed value on our work and checking in regularly for progress reports helped maintain momentum.

We had (and still do have) frequent discussions around whether the right people had been included/engaged with the meetings, "was there a 'good enough' balance between professionals, services users, carers and the third sector?", "did those that attend feel they could meaningfully contribute?". In particular, one huge gap has been in maintaining ongoing carer involvement. Whilst we have had some carers work with us for short periods, they have reported finding this difficult to balance with other commitments. As yet, we have found this difficult to resolve. We never reached a final conclusion to any of these issues or questions, but these were and are topics that needed to be kept regularly on the agenda; quite literally we soon made 'meeting representation', particularly from a service user and carer perspective the first standing item of our agenda. As part of this, we often debated about whether, how and when to include potential new members. We strived to be as inclusive as possible, but were also aware that introducing new people to the process in an unplanned way could be detrimental as explored below.

We needed a lot of time to just get used to being a team. Group members who were service users in particular felt they had to *'learn how to contribute'*. Unlike those camped together at the foot of a mountain, we only met once monthly and it took us a while to realise that we needed time to warm up to each other again when "back at camp". It was as if we all had our own forays to make in between these meetings; these could take us off anywhere and everywhere. When we re-joined base camp we each had different levels of energy, concentration, pre-occupation with where our forays had taken us that could interfere to different degrees with cohesiveness and productivity within our team. We introduced regular icebreaker exercises at the start of each meeting and name plaques for the table. We also created a 'who's who' map of everyone involved (whether through attending or more indirectly) to be shared with new members. Thus we began to actually 'do' co-production within our meetings, as a testing ground for how we might do it across the service. We made sure that we were all on an even footing, with each person's views considered equally valid. We adjusted the meeting style to account for those with more difficulties in attention and concentration or who simply may not be used to attending meetings. This included strategies such as creating an informal atmosphere with refreshments, encouraging and making space for people to ask questions and using exercises that got us talking to each other as real people with likes and interests.

On reflection, perhaps it would have also helped to meet more frequently at first and spend some time on team building. It certainly would have helped if we each had been able to allocate more of our time specifically to this project, but unfortunately this is not always practical. However, after a while, we began to feel like a more productive team – one turning point was when we took up a group member's suggestion for sharing a Christmas meal together. We all brought an item to share for a buffet and there was perhaps something about this communal act and that of giving ourselves permission to spend much longer on the social aspect of the meeting that helped us to bond more closely. For the professionals involved, there had perhaps been some hesitation in this ('*not another work Christmas do to try and fit in*'!) but there was something important about acknowledging ourselves as a separate entity, a team within the overall R&R team in its own right. It was maybe at this stage that we began to be and feel more ready for the next part of our journey.

Navigating the foothills

Our meetings acted as something of a practice ground for the very co-production we were working towards in our services – they gave us a place from which to practice small journeys into the foothills of our mountain; to work out how to work together, plan out routes to take, identify what resources we needed etc. We did not always get it right straight away, but over time it seemed as if group members became more comfortable with expressing when things were not working as well as they could be and less afraid to try things out to see what helped improve the process. However, it felt for a long while like we were attempting to find ways forward and out of base camp, without really being clear about which way to go or exactly where we were headed. This may be something to do with the lack of experts to guide us. – Even those of us who thought we knew about what was needed to start with soon realised that new ways of working were needed as the process '*challenged what we thought we already knew and we had to learn not to assume or take things for granted'.* We were all novice mountaineers in this and it was important that we saw ourselves as on an equal footing; we did not have the luxury of Sherpa guides. We knew we needed to look at the literature for guidance on how to progress and found that advice was plentiful. In addition to those already mentioned, some of the most helpful guides we found on service user and carer co-production and involvement include Tait and Lester (2005), Ramrayka (2010), and the Department of Health document on reward and recognition in relation to payment for time and expenses (2006) .

However, there still remained the challenge of identifying strategies & policies for putting these guidelines into practice and operationalising them. As there was so much out there, we did not want to simply replicate what others had done in producing a lengthy list of guidelines. We wanted to create something that was meaningful and practical for the services we were involved with. We therefore began to meet with and invite others involved in similar work along to our strategy meetings so that we could learn from them and have the opportunity to reflect on how these things might be relevant to our work. Although such meetings did not provide a 'how to', each brought a different piece of the puzzle and this helped us to make decisions about what we did and didn't want to replicate and learn from. In the words of one member, it has been the range of *'richness and diversity'* within our meetings that has helped us to learn so much.

However, it was difficult to explain to those who weren't on our journey with us (or those who came along only for brief periods) exactly what we were doing or where we were going. At times it was hard to be sure ourselves. Some of those who came along for only one meeting often spoke off topic and appeared to find it hard to contribute. This is of course no wonder when you realize that such individuals may have had little experience of attending meetings and all the formal etiquette that those attending them regularly often take for granted. Senior colleagues within our services appeared skeptical about whether we were really going anywhere at all. We would find ourselves as if sat at the foot of the mountain, on pause trying to explain our purpose and this sometimes made progress even harder. On reflection, it may have been helpful to have some individual time with those new to the group. However, over time, we have begun to get a little clearer. One group member noted that it is as if we now have a destination to put in our 'Satnav' that would help us find the best path up the mountain. Alongside, we developed a model of co-production based on experience and aspiration (see Figure 1). As can be seen in the model, each of the levels is associated with key actions and processes needed to achieve long term, sustained co-production. Whilst the targets identified within each level are not exhaustive (and to some extent are suggestive rather than prescriptive) we believe that it is important that the ethos of each level is followed in order that co-production achieved be realistic, meaningful and sustainable. However, it is acknowledged that adaptations are likely to be needed for different services and that it may not be necessary to achieve them in their entirety before engaging at the next level. Each of the levels are outlined in turn.

INSERT FIGURE 1
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Level 1 'laying the foundations' to co-productive working.

Based on our experience, this level is initially the responsibility of professionals and / or service providers. This level begins with recognising 'we value what you have to say, we want to listen and work with you'. This statement of intent provides those who use the service,

their families and friends an opportunity to examine whether or not they can believe this to be true and worthy of their engagement. In some ways this could be likened to moving within the stages of change model (Prochaska and Diclemente, 1989) from pre-contemplation to contemplation on the part of the organization. Depending on the history of the service and the journey that clients have been on to get there, this stage might take more or less time. For example, when there are issues with trust, feelings of hopelessness, of having been through a revolving door within the client group then people may need more time spent on opening these pathways of communication both ways. The ethos emphasised in Australian Guidance of 'If you want to go fast walk alone, if you want to go far walk together' is perhaps of particular relevance to keep in mind, particularly when progress feels slow at this stage (Mental Health Commission of Western Australia, 2014). However, regularly meeting with service users and carers, asking for feedback, responding to issues raised and feeding back the outcomes can start to build an ethos of partnership working. It is here that some of the strategies from clinical practice such as the Safewards initiative (Bowers, 2014; currently also being implemented across R&R) may fit particularly well and demonstrate the wish to listen and work with.

Level 2; identifying and building skills.

The more that pathways of communication are established, the more individuals can begin to test out and build confidence in asserting themselves. It is likely that individuals (staff, service users and carers) will benefit from considerable support and training at this stage to help nurture and build on these emerging skills. It will be the responsibility of professionals at this stage to look out for opportunities to help service users and carers they work with to identify and utilise their strengths and build on areas of perceived weakness. It will be the responsibility of all involved (professionals, service users and carers) to remain open and honest about their experiences of these processes and of what works and what doesn't for them. This is essential as considerable trial and error may be needed to help people navigate hoped for, feared and expected consequences of trying out new roles. Potential power imbalances will need to be identified and discussed. It is only by working together in these ways, across multiple contexts and on an equal footing, that a shared understanding can be reached and true partnership working can be established. At this stage all ventures that can be tackled jointly with service users, professionals and carers working together should be.

Level 3: working in partnership: co-production.

With level 2 serving as the testing ground, level 3 reflects widespread partnership working. This is captured in the concept of 'nothing about us without us' (e.g. James, 1998). Carers, service users and professionals at this stage should have the knowledge, skills, experience, confidence and appropriate support to work in partnership across all aspects of service design and delivery. However, even in a service that has worked its way towards Level 3, this does not mean that all those who use the service and their carers will want or be ready to work in partnership on all things. New people from whichever background who join the service are likely to need time and support to work their way up through the levels. Some may never reach or aspire to reach that point; however, Level 3 services will ensure support and opportunities for those who do. It may be particularly important for those within the service to maintain engagement with interested parties who have moved on as their skills and experience may be particularly valuable in buddying, mentorship, consultation and other supporting roles.

In order to reinforce, enhance and support each of these levels, a clear service ethos or guiding principles need to be outlined, appropriate payment and reimbursement of expenses must be developed (with consideration for how this may work across the levels) and a programme of training will need to be in place.

This model is intended to provide a process guide to the changes in culture that are needed to move through the steps suggested by Arnstein. In this way this partnership working guide can be seen as a template for operationalising a tailored process for embedding co-production.

What have some of the challenges been along the way?

Some of the challenges we have encountered can be seen outlined in Table 1, alongside strategies we have used to tackle them and / or ideas developed through reflection. Some overlap can be seen between these and those identified by others in the literature. For example, Husband et al (2010) highlight challenges including lack of information and knowledge, insufficient resources, difficulties in recruitment. They also highlight 'resistance to

the idea of users as experts'; however this may have been less of a feature within our meetings due to the gathering of like minded individuals.

INSERT TABLE 1
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What have been the key achievements in developing our strategy to date?

Beginning to climb Everest

It's hard to say how high up the mountain we currently are. But it does as least feel like we have started to climb now and this is an extremely rewarding sensation. Our model in Figure 1 is now the catalyst for this, serving as our map and guide for continuing to move forward. One group member has described it as '*amazing...I feel I'm giving back what I took*' [to services] and that it has *'increased my confidence'*. Another as '*motivating, inspiring, energising'* and a colleague from a related service described the process of being '*a privileged observer'* to our work as '*innovative, positive and aspirational'.* When we reflected as a group about what our key turning points towards making progress and developing the model have been, it was interesting that we each identified different things. Some reflected on the importance of just getting together; of "*moments of sitting at the table, seeing numbers and people represented; feeling proud*". It was certainly no mean feat to achieve representation from such a range of settings. There was also something important about producing 'tangible' records of our work; our terms of reference, a completed literature review, a business plan. These helped us to focus and gain clarity on what we were doing, to have something to demonstrate our work to others and to feel like we were achieving (see Table 1). One aspect we also all agreed on was the importance of achieving appropriate payment for the time of the service user and carer volunteers. In the words of one member; '*payment made it real'* as it meant '*being taken seriously' and 'treated with respect'*.

However, we are more than aware that we are still nowhere near the top of the mountain. We still have so much to do in terms of putting our ideas into practice, testing them out and then quite probably revising them further. We are bound to have more frustrations ahead, but we have learned that a key part of this is to '*trust in the process of sticking with it… the*

synergy effect of meeting as a group and the additional ideas and energy that provides'; therefore the process may be slow but the journey is worthwhile.

Next steps:

The journey so far has taught us a great deal (both about the true nature of the challenges this way of working brings and ways to navigate them as outlined in Table 1.) and so we now feel in a stronger position in which to guide others. We need to continue to develop our resources and practice and have recently developed a set of core guiding principles and a payment and reimbursement policy which we have been testing out to good effect (our model in Figure 1. Highlights that these play an important role in supporting movement through the levels identified). We plan to add to these next with a service user and carer handbook. This will include job descriptions for roles, recruitment and exit strategies and an associated training and support package for all those involved. Following this, we plan to develop an accredited training programme that individuals can progress through as they move through the levels in our model. We have begun to explore and make links with a local training provider to identify areas of overlap and potential collaboration with courses they already provide. This is in the early stages of exploration and development but we feel that something like this will help to formalise and incentivize the process.

In general, Ramrayka (2010) also emphasizes that principles of recovery, respect and equality should be incorporated throughout co-production work and advocate for the appointment of Service User and Carer involvement 'champions' within the organization in order to facilitate this. Related to this, we feel a key factor that will further help build and maintain our momentum will be that of appointing a full time co-production project worker, ideally someone with lived experience and we hope a bid for this will come to fruition shortly.

We are now making a bid for the summit – it will probably be the first of many. When we get there we may well realize there are yet further peaks to climb, and we will of course need to support each other back down the other side – probably (hopefully) with a lot more people on our team. We will however be equipped with an ever growing understanding of the both the challenges and the solutions to doing this in practice (as in Table 1). We hope in time to be able to use these skills and experience to move beyond Level 3 and include work with local

communities tackling stigma and discrimination and promoting wellbeing. We hope that this will help us move towards a broader model of co-production with the people and places that those who use our services will be living out their lives in.

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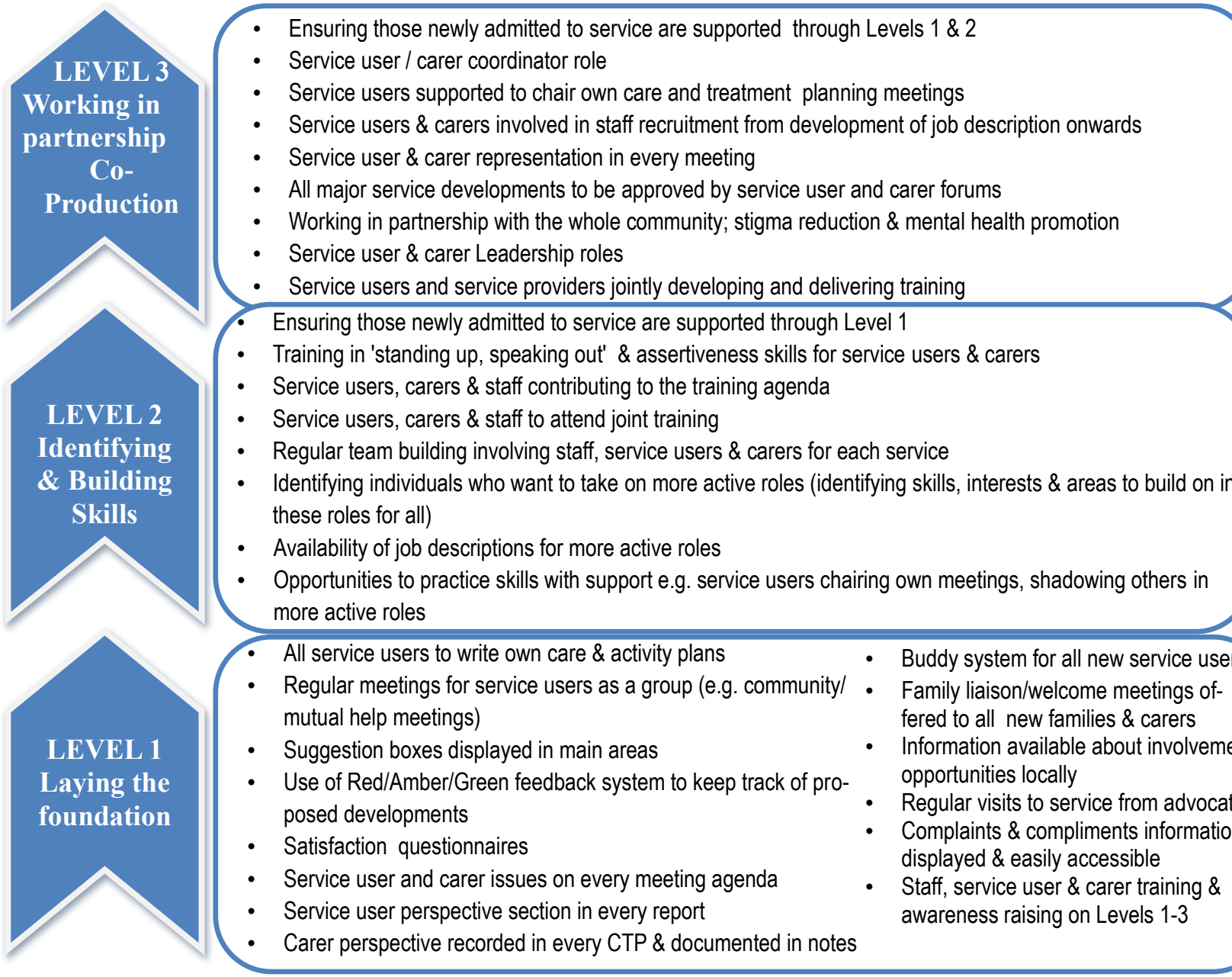
Our challenges	What worked for us / other ideas to tackle potential challenges
Getting to know each other/breaking down barriers	- Name tags or plaques on the table - Regular Icebreakers including those that highlight similarities rather than differences within group members - Team building exercises - Social events e.g. communal buffets - Map of who's who for reference in the meeting - Meeting with new members pre and post meeting and regularly to see how settling in - Buddy system – not turning up alone - Talking openly about changes to relationships that might be involved
Managing the time commitment	- Pooling resources; working out what areas can work together on - Paying appropriately for time - Ensuring commitment of managers including senior staff (for moral and practical support) - Aligning work with our core values - Nominating representatives from each service area to act as a link
Project fatigue / managing frustrations of slow progress	- Developing clear terms of reference - Revisiting meeting purpose regularly - Setting deadlines - Draw out a business plan - Identifying and aiming for some 'quick wins' especially early on - Not getting too carried away; keep it realistic and start small - Identifying good practise and what's already been achieved - Identifying hopes, fears and expectations as go along for those within and outside of meeting. - Deciding what and how to communicate to others not present - Holding onto the fact that this is part of the process sometimes – need to ride it out and see where it goes - Not assuming everyone understands / remembers just because have been through/ discussed it previously
Building carer involvement	- Linking in with already established groups - Going to people rather than expect them to come to us - Identifying potential people who may be interested at an early stage - Offer support to overcome any practical barriers
Organising appropriate payment	- Identifying other local examples of good practise - Link in with key local HR and finance personnel - Be persistent - Ensure payments are is in line with / don't cause conflict in relation to state benefit payments for service users - Ensuring safeguards for those handling money/making payments
Drop out / attrition of membership	- Constantly make and maintain links with all parts of the service and those related to - Seek feedback from those who leave to identify reasons; make changes accordingly - Co-production liaison / project worker role to help build and maintain links and en-

	gagement - Support of third sector - Posters to advertise - Appropriate payment offered

Table 1: Challenges and solutions in developing co-production.

Figure 1: Partnership Working: A Guide to Co-Producing Rehabilitation and Recovery Ser



*** See relevant policies for more information on overarching principles & troublesho strategies to facilitate the process**