Elevating the Voices of Latrobe Communities

Development of a flexible model for community engagement

Research paper

THE AUSTRALIAN CENTRE FOR SOCIAL INNOVATION

Prepared with care for the Office of the Latrobe Health Advocate by TACSI

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We pay respect to the Traditional Custodians of all lands, past, present and future. Honouring our Elders and nurturing all young people.

Introduction

In the 2014 Hazelwood Mine Fire Inquiry, the Board proposed that the Latrobe Valley needs a local health voice that can win the trust of the community and be a sound source of advice, mediation and advocacy on health-related matters. The Board also suggested that a Health Advocate could provide leadership and assist in communicating and engaging directly with the community about health matters.

The Latrobe Health Innovation Zone

The local government area of Latrobe City is located approximately 150kms east of Melbourne. It is recognised as one of Victoria's major regional centres and is one of six local government areas that make up the broader Gippsland region.

Latrobe is home to 75,211 residents and 5,019 businesses. Latrobe City is made up of four central towns; Churchill, Moe, Morwell and Traralgon, and several rural townships; Boolarra, Glengarry, Toongabbie, Tyers, Traralgon South, Yallourn North and Yinnar.

Latrobe has traditionally been recognised as the centre of Victoria's electricity industry with local coal mines and power stations providing significant employment opportunities and contributing to the local economy for much of the past century.

In 2014 a fire ignited and took hold in the Hazelwood Coal Mine, it lasted for 45 days. Latrobe communities were significantly impacted by this event and subsequent Hazelwood Mine Fire Inquiries were held. These inquiries found that the health profile of the Latrobe Valley is poorer compared to other local government areas in Victoria and the average for the state. The Inquiries established that there was a strong case for the health of the Latrobe Valley to be substantially improved.

In response to the 2014 -16 Hazelwood Mine Fire Inquiries I and II the Victorian Government designated the Latrobe City local government area as a Health Innovation Zone, the first of its kind in Australia. This designation included the establishment of the Latrobe Health Assembly and appointment of the Latrobe Health Advocate.

The Latrobe Health Advocate and Latrobe Health Assembly are key structures within the Latrobe Health Innovation Zone to empower communities to have influence on health promotion, health planning, priority setting and service and program design.

Introduction

The Latrobe Health Advocate

As Latrobe Health Advocate, Jane Anderson provides independent advice to the Victorian Government on behalf of Latrobe Valley communities on system and policy issues affecting their health and wellbeing.

Jane maintains a focus on strategic outcomes and systemic change, ensuring advice and activities within the Zone are informed and underpinned by a strong collaborative approach. In doing so, Jane listens to and analyses community voice, and explores priority projects in depth. Jane then collaborates with others including the Latrobe Health Assembly and local health services with a view to influence implementation.

Communities are clear about wanting the Zone, Assembly and Advocate to:

- Improve community opportunities and perceptions.
- Improve community connectedness and participation.
- Improve health service access and design.
- Improve health and lifestyle.

Purpose of this work

One of the priorities of the Advocate is to enable inclusiveness of marginalised communities within Latrobe Valley. There are groups of people in Latrobe Valley who experience exclusion for reasons such as age, health, economics, education or they may live in an area that is not easily accessible.

The ultimate outcome of this work is to design and develop a community engagement model with people experiencing disadvantage through disability, financial stress, isolation, family violence, chronic disease, mental illness, sexuality, cultural diversity, and age.

Discussions to date have determined that effective engagement model for the Advocate will enable:

- A breadth of voices to be heard and re-heard.
- Barriers to participation to be named and addressed.
- Engagement on communities' terms.
- Power and power imbalances to be effectively named and tamed.
- Communities to be engaged beyond 'advice giving' and into co-production.

Introduction

Project stages

1. **Desk research** to explore different models for engagement used by organisations in related fields.
2. **Conversations** with people running different kinds of engagement models in Australia and New Zealand.
3. **Strategic workshop with community stakeholders** to determine the goal model of engagement for the Office of the Latrobe Health Advocate team.
4. **Testing and implementing** the model.

Research questions

Through the broader project we are exploring the following questions:

1. How does the Latrobe Health Advocate engage the right people, well and to maximise benefits to them?
2. How does the Latrobe Health Advocate maximise influence on government and others?
3. How does the Latrobe Health Advocate think usefully about 'place' and the communities within place?
4. How does the Latrobe Health Advocate organise itself within it's resource and remit constraints?

Thought the desk research and the conversations, we've been primarily exploring questions 1 & 2.

We have not identified literature that is strong on useful ways to conceptualise place (question 3).

Question 3 and 4 will be further explored through the strategic workshop.

This paper introduces a range of engagement models, a framework for thinking about engagement and evidence on the benefits and risks of engagement. In each section we pose reflective questions to connect these examples to the work of the Latrobe Health Advocate.

Engagement models
An overview

Overview of engagement models

This section provides an overview of the 4 different kinds of engagement models we explore in this document and provides frameworks to compare them.

Engagement models

There are many different traditions of engagement the Office of the Latrobe Health Advocate (LHA) could consider to adapt for their context.

In it's first year LHA has focussed on conversations with individuals and organisations and online engagement to seek people's opinion on aspirations, barriers and opportunities. The the Office of the Latrobe Health Advocate has paid particular attention to maintaining feedback loops with community members, and also making use of the media. Forms of engagement that would fit in the tradition of community engagement or community consultation.

In this work we have explored 4 different 'traditions' of engagement to inform the development of the LHA engagement model.

1 Deliberative Democracy approaches which have been developed for used in democratic contexts to reach citizen judgements on continuous issues. This approach has a focus on discussion and the political legitimacy of the decisions made.

2 Participatory design approaches (co-design) which are increasingly used in public service settings to understand needs, define opportunities and detail service responses. There is a focus on identifying opportunities and prompting innovative responses.

3 Co-production type approaches which stretch the engagement of citizens not only into the design but the delivery, planning and commissioning of services or responses. There is a focus on the integration of citizen experience into every part of development and delivery.

4 Kafka Field Lab approach - an approach designed specifically to respond to government service delivery issues from the perspective of end users. The approach draws on ideas from systems thinking and advocacy, and has a particular focus on prompting change in a public service context.

The models are illustrated by 8 examples of application.

Overview of engagement models

The models we explore in this document are differentiated on a number of factors. Here we outline one model to think about these differences - this may aid decision making for what's needed in the LHA engagement model or a choice framework for deciding on a particular approach for a specific situation.

Engagement goal and promise

The models vary on the way citizens are engaged and the related outcomes for them. Some are more about informing, some more about mobilising. The IPA2 public participation spectrum (page 10) provides a framework for thinking about this in more detail.

Purpose of engagement

Some models, such as Citizens' Juries are about making a decision, some such as the Kafka Field Lab model about responding to a problem, whilst others such as Participatory Design can be used to generate a future vision or design a detailed response to that vision.

Ambition of engagement

Some models, such as the Kafka Field Lab model relate to more incremental problem solving, whereas Participatory Design methods can lead to more radical solutions.

Ability to engage marginalised groups

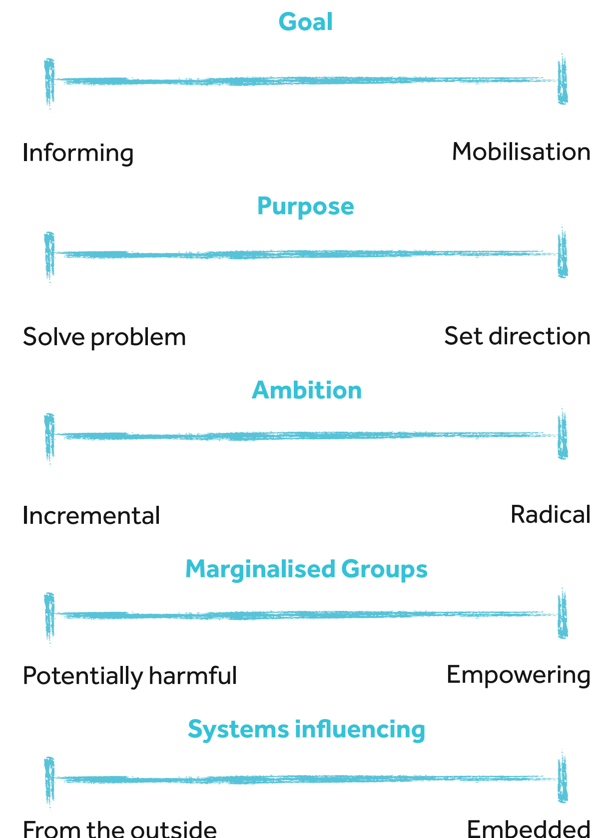
Some models, such as Participatory Design approaches are particularly well suited to understanding the prospective of marginalised groups. Others, such as Citizens' Juries may be potentially hostile environments for marginalised groups.

System integration and influencing

Some engagement methods, such as co-production build engagement into the normal operating model of a system. Others conduct engagements as occasional or one-off projects, Citizens' Juries are often used in this way.

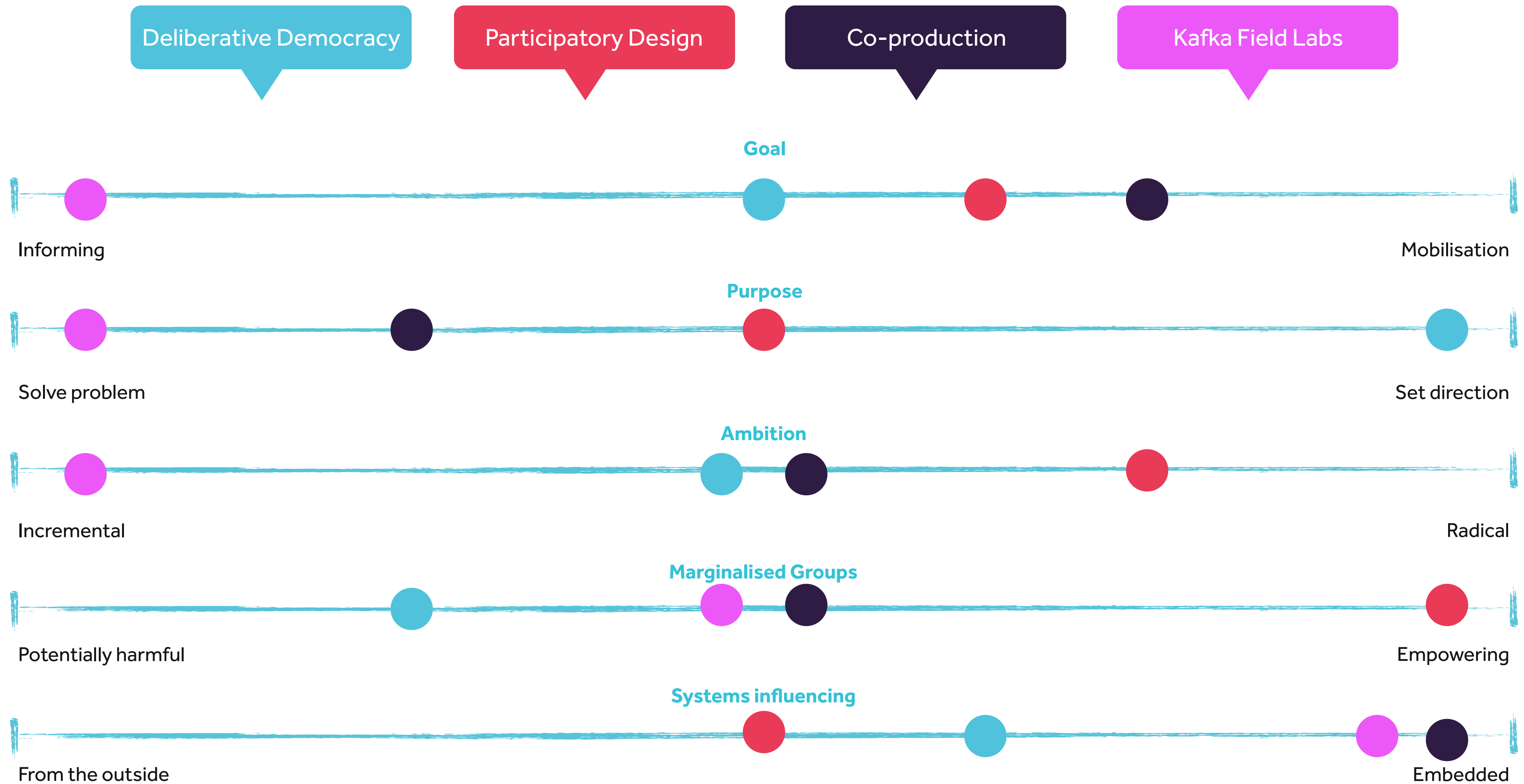
Further investigation could be done into models operating at scale. Below two examples:

- Platform to engage young people in New Zealand: Upsouth
- Platform to share experiences of health or care services in the UK: Care Opinion



Weighting of engagement models

This illustrates the weighting of particular models. Dots at the centre balance both ends of the spectrum.



IPA2 Spectrum: Engagement goal or promise

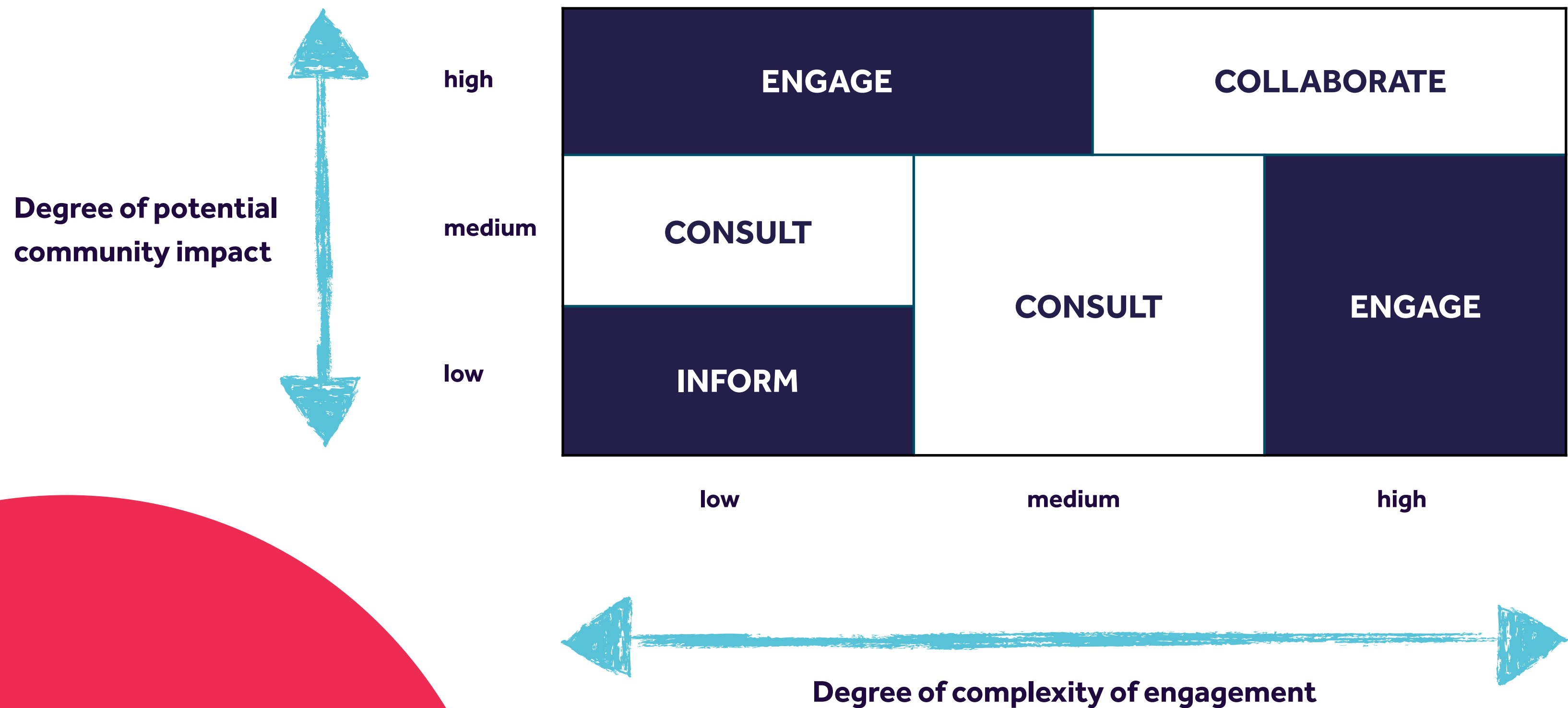
This well known framework provides one way to think about varying engagement goals and the associated promise to community members.

Increasing impact on decision making →	INFORMING	CONSULTING	ENGAGING	COLLABORATING	EMPOWERING
Community engagement goal	To provide people with balanced and objective information to assist them in understanding the challenge, alternatives, opportunities and/or solutions.	To obtain peoples feedback on analysis, alternatives and/or decisions.	To work directly with community members throughout the process to ensure that people's aspirations are consistently understood and considered.	To partner with community members in each aspect of the decision including the development of alternative and the identification of the preferred solution.	To place final decision making in the hands of the community.
Promise to community members	We will keep you informed.	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how community engagement input influenced the decision.	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how community input influenced the decision.	We will look to you for advice and innovation in formulation solutions and incorporate your advice and recommendations into the decision to the maximum extent possible.	We will implement what you decide.

IAP2's public participation spectrum.

IAP 2 Spectrum - Modified

This modified version of the IAP2 spectrum takes into account how engagement needs to account for complexity.



Adapted from IAP2 and the City of Onkaparinga Community Engagement Matrix.

Engagement models
Examples

Deliberative Democracy: Citizens' Juries

Deliberative Democracy approaches are participatory approaches that have developed to support political decision making. Deliberative democracy holds that, for a democratic decision to be legitimate, it must be preceded by authentic deliberation, not merely the aggregation of preferences that occurs in voting.

Citizens' Juries are a particular deliberative method which brings together a statistically representative group of citizens come to a judgement informed by experts and their peers.

Deliberative principles have also been applied to online engagements, which may deserve further investigation.

Considerations

- Deliberation between a diverse group of experts has shown to shift opinion and preferences.
- Politically legitimate Citizens' Juries can be expensive to set up and run.
- Citizens' Juries can have high levels of political legitimacy and even directly decide new policy and legislation.

Deliberative Democracy and LHA

- How important is it to get beyond opinion in engaging citizens views?
- Could Citizens' Jury model, or aspects of it, be used to develop public judgements that would have increased legitimacy with government?

A citizen juror delivering the recommendations to government, Citizens' Jury on Sharing the Roads Safely 2014

What LHA learned from speaking to the team:

- **How to engage stakeholders.** Communicating what the experience is going to be like from the very beginning, having an independent facilitator not representative of government and making sure different parties understand who owns the process.
- **Impact and influence.** The process endorsed policy direction, influenced legislation and led to investment. Participatory budgeting process brought efficiency saving for Treasury as community feedback to prioritise grant making.
- **We wonder...** how might we find ways to engage marginalised groups, e.g. CALD communities and people living with a disability, in a meaningful way in this type of engagement?

Citizens' Juries in South Australia

Citizens' Juries have been used in South Australia to develop a public perspective on issues including:

- A vibrant nightlife / alcohol fuelled violence in Adelaide.
- Shared road usage between bikes and cars.
- Rules relating to responsible dog and cat ownership.

This has lead to a number of changes in policy and law.

Supported by the previous Labour government who under the Reforming Democracy agenda aimed to change the way democracy is done in SA, creating a new balance between experts and the public and giving elected representatives confidence that public judgment (rather than opinion) contributes to better decision-making.

Citizens' Juries involves the following stakeholders in the process:

- Citizen jurors
- Bureaucrats
- Experts and social interest groups
- Facilitators

Highlights:

- Recognises the value of the intelligence and experiences of everyday people.
- Citizen jurors felt empowered by the opportunity to work with people in power.
- Some bureaucrats, special interest groups and jurors were uncertain if the jury added value to the policy areas.

You can read more in TACSI's report 'Verdicts on the Jury' an evaluation of the experience of South Australia's first Citizens' Jury.

Participatory Design

Participatory Design approaches engage a small team of citizens and experts to collectively design innovative strategy, services or systems through a staged design process which typically involves understanding issues, identifying opportunities and prototyping solutions.

There are several different design-based approaches that engage end users. They include expert led workshop based approaches (design thinking), expert led consultative approaches (human centred design) and approaches that build the capability of citizens to be active participants and pay particular attention to addressing power imbalances between people and professionals (participatory design).

In Australia these different traditions are all referred to as 'co-design' (in New Zealand co-design is often used to refer to a more participatory tradition).

Participatory approaches are particularly well suited to engaging citizens experiencing marginalisation. TACSI have effectively used participatory approaches to engage people living with disability, LGBTIQ people, Aboriginal and Torres Strait Islander people, people with lived experience of mental illness, CALD groups and older people.

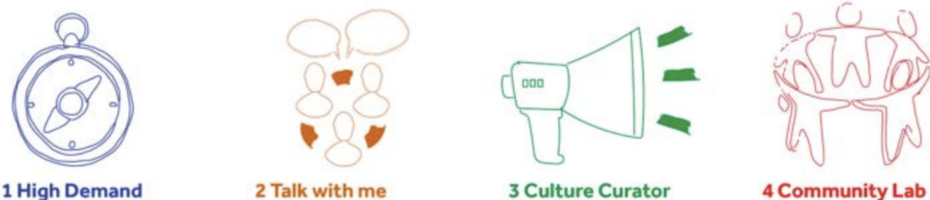
Co-design is also one phase of Co-production (explored next) and involves actively involving all relevant stakeholders in the design process to help ensure the result meets their needs and is usable. Stakeholders involved will differ depending on the issue being tackled.

Considerations

- Can create a safe and empowering space for participation by marginalised groups.
- Focus on innovation, i.e. creating better models.
- Particularly well suited to understanding and re-designing citizens experience of services.
- Requires specialist capability.

Participatory Design and LHA

- How important is it to get beyond opinion in engaging citizens views?
- Where might LHA engage in participatory design processes, and when might it recommend participatory design processes to government?
- What can LHA learn from Participatory Design tradition about engaging marginalised groups?



What LHA learned from speaking to the team:

- **How to engage community.** Empowering community to lead the work and transitioning ownership to the community. Building trust was key and the commitment of the organisation to co-design.
- **Ways to influence.** As a first starting point, the team got community members and government representatives together on the table, and the co-designers were able to share the insights from the community directly to decision makers.
- **We wonder...**How might we transition work from community to government? Would a governance group be helpful? How do we bring people along on what we are learning?

Co-designing with the South Sudanese Australian community

Exploring how to make engagement meaningful and facilitating collaboration between community and government.

The approach tailored for this project was informed by a community development approach specific to South Sudanese immigrants in Australia. It focuses on creating agency within the Sudanese community, mutual collaboration in design and decision making, and responsiveness to the evolving needs of The South Sudanese Australian Community.

The approach is characterised by the following key principles:

- Build genuine relationships.
- Empower community to decide, lead and implement.
- Prioritise context and culture in ensuring opportunities are relevant.
- Encourage participation through a ‘doing with’ attitude.
- Long term sustainability through building Champions and transferring ownership.

Community Co-design Team

A central component of delivering a community centred approach was having a team that included research and design experts, as well as experts in South Sudanese Australian culture and community. These co-designers were employed to listen to and advocate for their community in every stage of the project.

Governance Group

The Governance Group that advised the project direction at key stages included 1-2 DHHS (Department of Health and Human Services Victoria) staff, 1-2 Cohealth staff and 3 leaders from The South Sudanese Australian Community. The Governance Group worked to equalise power in decision making and ensure that the project was led by community needs while considering existing conditions.

What LHA learned from speaking to the team:

- **Health benefits of engagement.** Participating in the process helped people validate the challenges they were having and realising they are not the only ones experience the issues. There was value on social connection and building collective knowledge when coming together in a group.
- **Preparing people to engage.** Important to prepare people ahead of the session, clarifying expectations and mentioning there might be different perspectives and that we may not come to a consensus. Clarify we are not looking for alignment, what the roles are and agree on ground rules (e.g. how what they say may affect other people).
- **We wonder...**How do we hold the space not to have a conclusive recommendation but to keep it as a continuous collaboration?

Co-designing with people living with a disability

Exploring how to best engage priority groups and how to engage through to influence.

The four stages of this work are:

Semi structured interviews

TACSI and DHS (Department of Human Services - South Australia) staff met people at a place they choose (for example at home, a café or park) and spent 1.5-3 hours using questions and collaborative research tools to understand what good living, support, change and choice are for people.

Co-design sessions

The co-design group included people living in supported accommodation and a few already living in non-government supported accommodation. The group also included family of people living in supported accommodation and an Office of the Public Advocate representative. The group met, built on the research and refined insights, identified gaps and opportunities and collectively drafted what a good transition would look like for them, to guide the transition of Accommodation Services to NGO providers.

Final semi-structured feedback on key transition concepts

After the co-design sessions, DHS requested that we shared key outputs with the people originally interviewed, to ensure the material reflected their perspectives. Their feedback was incorporated in the principles checklist, provider principles and transition framework.

Establishing an influencer group

This group plays an important role in the continuation of a commitment to co-design. The influencer group would be made up of people living in supported accommodation and some parents and guardians who would work with DHS and their networks to continue to inform the transition of Accommodation Services, and the application of the Transition Framework.

A co-design+ approach to engaging older people

This mixed methods approach to undressing how older South Australians view ageing well included participatory approaches (story gathers) alongside more traditional research methods.

Methods used included:

1. **Story gatherers.** 18 older South Australians were trained across metropolitan and regional areas to speak with 75 older South Australians about ageing well. Story Gatherers that typically experience greater barriers to ageing well were selected: culturally diverse, gender and sexually diverse, had few financial resources.
2. **Community engagement.** The general public was invited to contribute their perspectives on ageing well in SA across two half-day workshops. Through this process, approximately 90 people were involved. In addition, the team heard from the Adelaide Grannies group, a network of Aboriginal grandparents who advocate on behalf of issues impacting their children, grandchildren and community.
3. **Survey.** An online survey was available and was promoted through a wide range of channels.
4. **Information scan.** A rapid desk review was carried out to understand the impact of efforts to date and identify further opportunities to support all South Australians to age well. Documents scanned included projects led, supported or commissioned by the Office for Ageing Well in the past three years, as well as relevant strategies and policy.
5. **Key informants.** Nine interviews were conducted with a variety of organisations working with or for older South Australians. The interviews included non- government agencies, universities, state and local government.

What LHA learned from speaking to the team:

- **Influence through lived experience**. Policy was shaped by people with lived experience and having a deep understanding of people needs and aspirations. Policy officers got the opportunity to have a conversation with older South Australians on what they would like to see. This experience influenced other three government departments in South Australia.
- **Authorising environment.** There is a mandate to do things differently. Everybody involved in the work needs to be committed to co-design and having champions is helpful.
- **We wonder...**What would story gatherers look like in Latrobe Valley? Would this be lead by Latrobe Assembly? How do we approach the tension between evidence based and community lived experience?

Place based Co-design The Southern Initiative, Auckland

The Southern Initiative, in partnership with Auckland Co-Design Lab, is integrating participatory approaches to support a multi-pronged place-based approach to 'champion, stimulate and enable social and community innovation'.

A key feature of the work is the engagement and capability building of Māori and Pacific Islander groups in small team co-design processes to influence services and policy. The team has engaged in a number of projects relating to health and wellbeing including Healthy Homes Initiative.

You can read more in TACSI's review of the initiative - Reviewing Strengths and Opportunities.

What LHA learned from speaking to the team:

- **Creating the conditions for engagement.** Without enabling a collaboration space and providing a bit of oxygen, it's hard to move beyond business as usual at the service level, specially in the health context. Sometimes it's about buying people out: *"We'll give you what you need to enable people to participate in a way that makes it possible for change to happen."*
- **Story of place.** Working at the local level - the communities are very different culturally, geographically and statistically from suburb to suburb. It's critical to test how the evidence/data actually shows up in a local context. Consider how everything we learn, suburb to suburb, builds on and reinforces the approach.
- **Ways to consider broader population.** Work with people doing longitudinal work to engage broader population level and LHA could focus on understanding deep.
- **We wonder...** How might the LHA collaborate with other partners in the Latrobe Health Innovation Zone? What are the roles each can play and to what extent can this be a joined up approach? How might LHA balance the depth and breadth of engagement? How might LHA create a culturally respectful engagement?

Co-Production

Co-production engages citizens (referred to as consumers) through the development, delivery and evaluation of services. It has particular traction in health and mental health settings. Co-design is one phase of co-production.

Co-production sees consumers involved in, or leading, defining the problem, designing and delivering the solution, and evaluating the outcome, either with professionals or independently. Co-production requires longer term engagement from professionals or clinicians, but leads to "profound and sustainable change" (Spencer et al, 2013, p. 7). The most important part of co-production is shifting mindsets and establishing a culture that embraces exploration and learning, and genuinely values consumer knowledge and expertise.

Considerations

- Co-production models integrate citizen engagement through the process of service design and delivery to ensure that services meet citizens' needs.
- Co-production is a significant shift in mindset, capability and process for health services and challenges structural power imbalances in the system.

Co-production and LHA

- To what extent might LHA advocate for adoption of co-production models in health - to ingrate citizen wisdom thought the process - beyond citizen voice.
- To what extent could LHA embrace co-production in its own operating model, what is the role citizens will play in the 'delivery' of engagement and the evaluation of it's effectiveness?

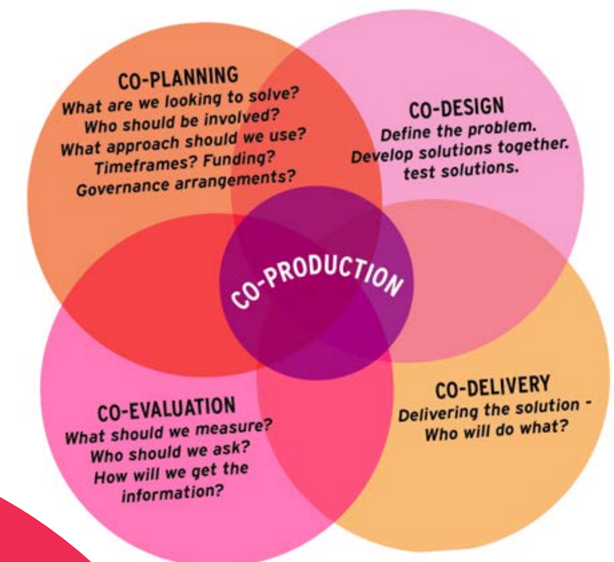


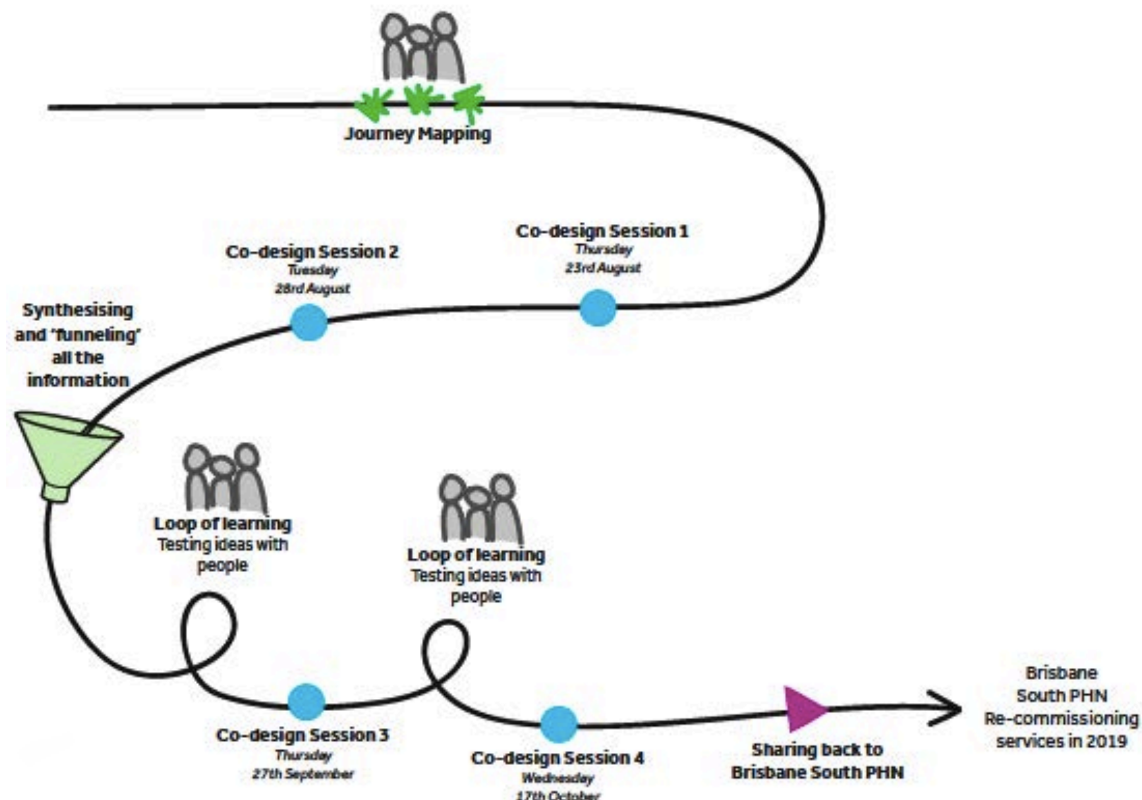
Figure 1. What does co-production involve?

Co-production in primary mental health

Brisbane South PHN have used participatory design approaches to develop a new service model for Primary Mental Health Services. They are now supporting providers to continue to co-design, co-deliver and co-evaluate the model.

In the co-design phase the work had three components.

1. **Journey mapping.** Mapping the journeys of each priority population was the first step in understanding the breadth and diversity of experience through the perspective of the priority populations, and from the perspective of those working within and across the system. The journey maps were then used to develop a shared understanding within the co-design group, in order to set priorities for design work and future commissioning.
2. **Working with a co-design group across four sessions.** The team invited a diverse range of people to join a co-design group:
    - People with lived experience of mental illness, suicide.
    - Those who work with or for people with mental illness (health professionals, managers, peer workers, Brisbane South PHN staff).
    - Provocateurs (curious and critical thinkers who sit outside the sectors we're working within). External provocateurs play an 'outsider role' - supporting the co-design group to think beyond the obvious, often through asking helpfully naive questions.
3. **Two testing cycles, called 'loops of learning'.** Between workshops, TACSI tested the group's ideas through phone and face-to-face interviews, collecting feedback on what people felt might work well, wouldn't work for them, and how they might improve the idea.



What LHA learned from speaking to the co-design team:

- **How to engage priority populations.** Meet priority populations through services & organisations that are already supporting the community. They may be better placed to know communities context better and they could participate in the engagement model process to provide support to the people.
- **Defining the starting point.** Start with desk research first to understand the unique reality of each priority group. From there, understand whether more research or action is needed.
- **Closing the loop.** Validate people's experience in the session (focus on strengths) and throughout the project always check in and share with people what we've heard.
- **We wonder...**How do we build capacity of providers? How could we bring in critical friends/provocateurs into the process?

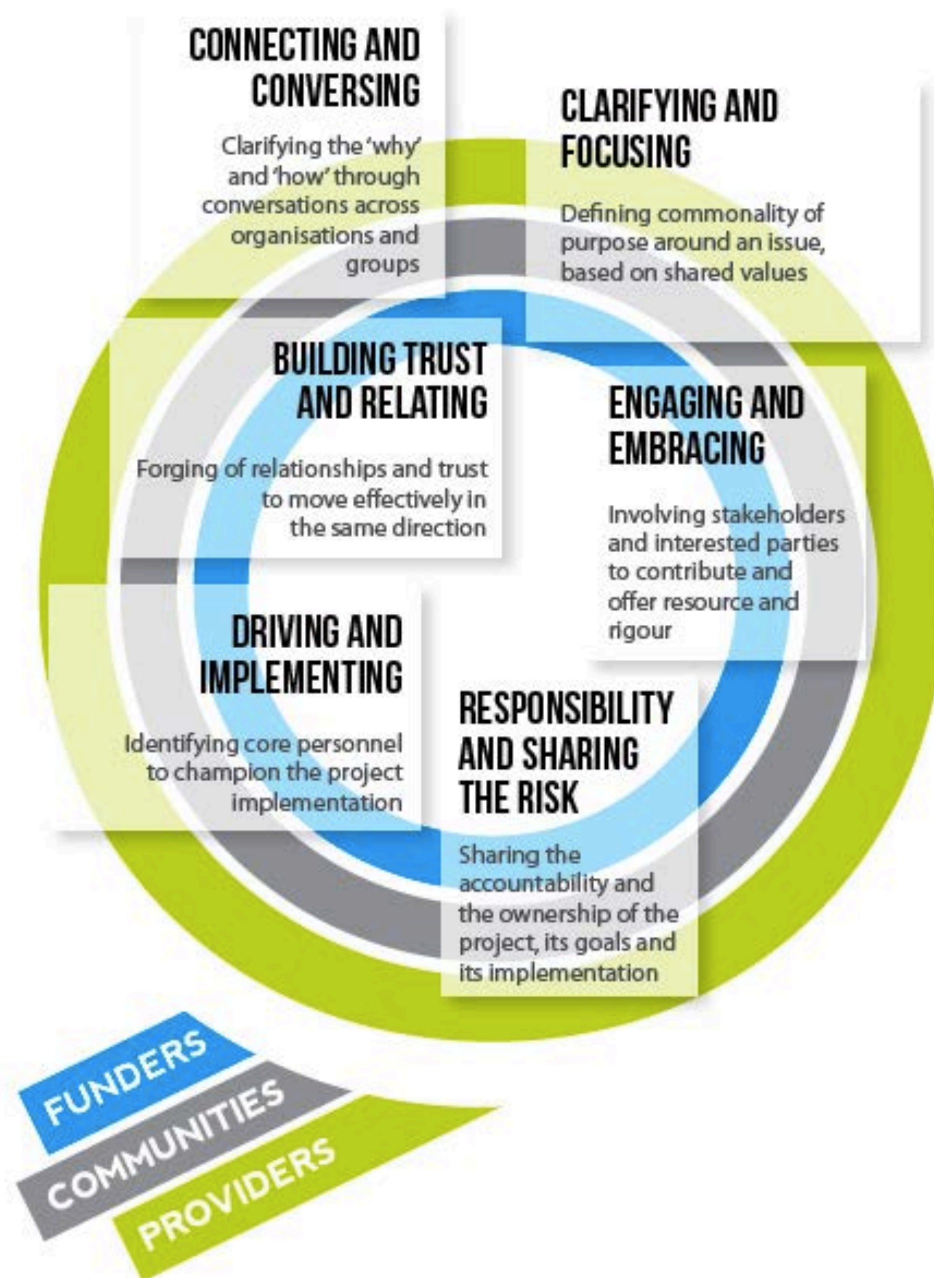
Showing up differently

Whilst it does not use the term 'co-production' this New Zealand based initiative engages citizens to collaboratively develop systemic solutions to complex issues. The model has been applied by members of Leadership Lab (a local leadership consultancy) to the co-design, funding, governance and implementation of a city-wide project in the post-quake context in Greater Christchurch.

Addressing complex challenges begins before solutions have been defined. In fact, it begins with the engagement of stakeholders around problem definition and funding. This compares traditional 'transactional' grant-making and procurement with more collaborative funder-provider-community relationships and explores the ways in which this can lead to the co-design of effective approaches to address complex challenges.

Lessons from the project shed light on the benefits and opportunities as well as the limitations and risks inherent in collaborative forms of governance, funding and facilitation. The reflections are based around these four key factors identified in the project:

- Determined collaboration around a compelling purpose ignites possibilities.
- Co-creation and co-design enables both innovation and ownership.
- Relationships are the currency that create a sustainable platform.
- Solutions are innovative, influential and exponential due to ripple effects.



Kafka Field Lab

The Kafka Field Lab approach is specifically designed to tackle issues of 'bureaucratic dysfunction' in a public service context by engaging public servants with lived experience.

The approach was designed to prompt change in the government context acknowledging the constraints and hierarchies that exist in that context.

Considerations

- Usually commissioned by a senior government leader, so that the approach has legitimacy within the bureaucracy.
- Potentially creates change for many citizens by engaging a single citizen.
- Findings are confidential, but if nothing is acted on the report is released publicly after 1 year.

Kafka Field Lab model and LHA

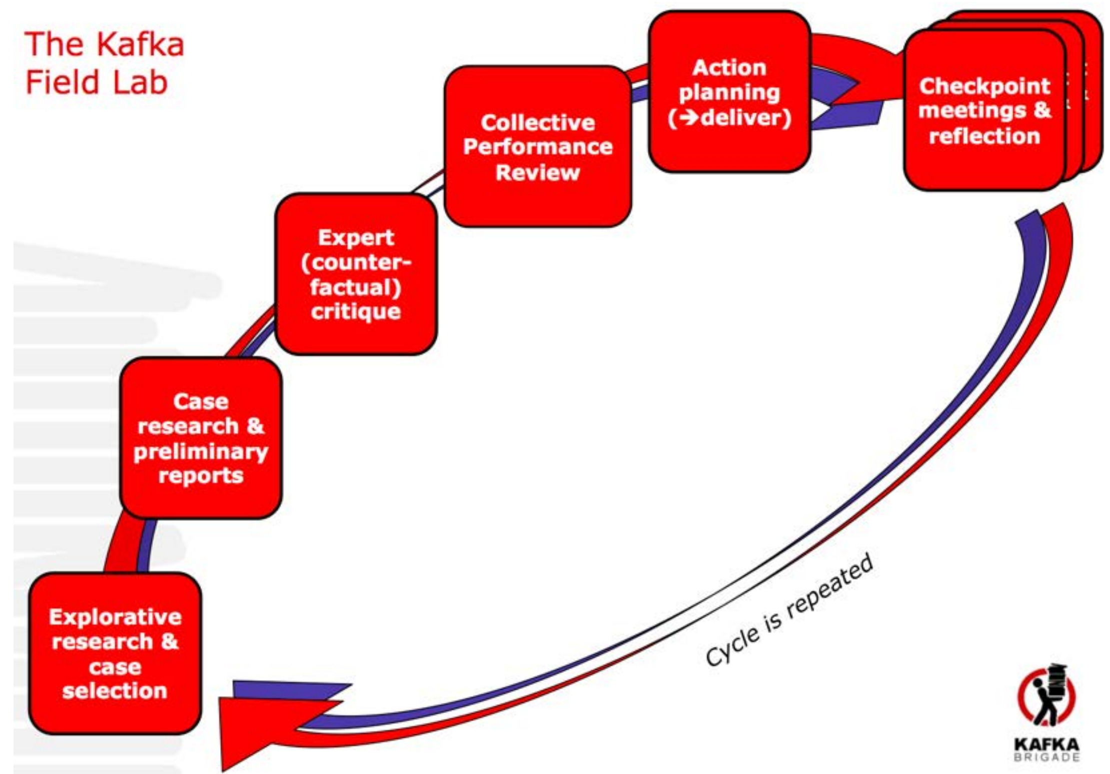
- How can common points of failure in health services be used as a leverage point for change across the system? What might these be in the Latrobe Valley?
- What can be learnt from the Kafka Field Lab approach about the engagement of public servants and other partners along a journey of discovery and problem solving?

The Kafka approach

An approach designed to catalyse change in a government context.

The Kafka method is a proven method of action research in which representative experiences – e.g. patients in a project in health – are used to identify barriers to delivering the public value for which the organisations are established, and to trigger a change process to remove those barriers. The method follows six broad steps:

1. **Explorative research and case selection.** Scope out the current understanding of the problem, and why the current situation has arisen. A qualitative exercise, drawing on available documentary evidence and the knowledge and insights of key contacts.
2. **Case research and preliminary reports.** Understand the problem more deeply from the perspective of the companies involved: everything from taxation, regulation, employment law, health and safety to support for Research and Development, exports, skills development and workforce inclusion. This builds up a rich picture of the experience of dealing with government from businesses' perspective.
3. **Expert critique of the preliminary analysis.** Identify all the agencies organisations are in contact with, and interview the front-line staff in each agency.
4. **Collective performance review (CPR).** Bring everyone with a stake in solving the problem together, e.g. front line staff, managers, policy professionals, politicians and other concerned parties.
5. **Final recommendations and action plan.** Package the agreed actions from the CPR, plus the Kafka Brigade team's recommendations and observations, into a concise, high impact action plan. The CPR will have energised people across the government system and identified a range of actions that will really make a difference.
6. **Delivery and follow up.** The commitments made at the CPR can only be delivered by the managers responsible across the government



Health risks and benefits of engagement
What the evidence says

1

Health benefits

There is evidence of health and wellbeing benefits of participatory engagement, particularly from mental health and co-production models.

Communities of place and communities of identity or affinity, have a vital contribution to make to health and wellbeing. Community life, social connections, supportive relationships and having a voice in local decisions are all factors that underpin good health (UCL Institute of Equity, 2013).

The literature tells us participatory approaches can directly address the marginalisation and powerlessness caused by entrenched health inequalities. The assets within communities, such as the skills and knowledge, social networks, local groups and community organisations, are building blocks for good health (Morgan A, Ziglio E., 2007).

In addition, evidence suggests that community engagement reduces inequalities in health, and working together to take action on health is a process leading to improvements in the determinants of health and an outcome in itself (O'Mara-Eves A, Brunton G, McDaid D, Oliver S, Kavanagh J, Jamal F, et al. 2013).

There are also strong conceptual links between well-being and co-production (Slay, J. & Stephens, L. 2013). A number of common themes and outcomes emerge from the literature:

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

Social networks and social inclusion

Benefits include stronger relationships with peers, family, and friends; a reduced sense of stigma associated with mental health conditions; and a greater sense of belonging to local groups, communities of interests, and networks. Common outcomes include improved social networks, feeling valued, greater community cohesion, reduced stigma, and reduced isolation.

Addressing stigma

A common theme emerging from literature is reduced stigma for those accessing mental health support and services. This had three aspects: reduced stigma experienced from professional staff in mental health services, less stigma in accessing services, and reduced stigma from the 'community'.

The key principles of co-production that address stigma are developing peer and support networks, and eroding boundaries between people and professionals.

Evidence suggests involvement in planning, commissioning and governance can improve information and access for service users, and have positive effects on decision-making processes and staff attitudes and behaviour. It is vital that service users are involved in defining the outcomes of services for these benefits to be maximised (Faulkner A, 2015).

Co-design must be seen not only with reference to the specific challenges is being able to solve, but also in terms of the foundations they lay for future progress: "it leaves behind compelling new social relationships between previously separate individuals and groups which matter greatly to the people involved, contributes to the diffusion and embedding of the solution space, and fuels a cumulative dynamic whereby each idea opens up the possibility of further innovations" (Mulgan et al. 2007).

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Risks of poor engagement

Evidence suggests that in mental health contexts, there is a risk that people participating in the engagement are not well prepared and don't have a clear understanding about what they have come together for and why. The experience of co-production process in mental health can potentially be emotionally and psychologically challenging for people involved. The need for support should be anticipated, explored and provided for if the process is to be successful (Carr S., Pate M., 2016).

There may be also a risk that restrictive administrative procedure and professional roles compromises the degree to which people can achieve parity and equality during the process, e.g. medicalised 'us and them' divisions between practitioners and service users. This requires a move away from traditional, organisational roles towards collaboration based on equal but different types of skills and expertise (Carr S., Pate M., 2016).

Co-production with allies from other disciplines is critical to the success of lived experience roles. However, research cautions that co-production must ensure lived experience voices have equal weighting and be enabled to lead in areas that are appropriate – particularly regarding recovery orientated concepts and the needs and priorities of people accessing services (Byrne, L., B. Happell, and K. Reid-Searl, 2015).

Therefore, co-production is challenging – it requires examination of processes and power at the organisational level and within groups, and requires participants to continuously explore power at an individual level. Because of the dynamic nature of power, it needs constant focus and attention to ensure its even distribution throughout the life of the initiative (Roper C., Grey F. & Cadogan E., 2018).

Co-design, enacted in this way, designates someone as having special capability to work with people who wish to achieve something, who then gives their work back to them, and appropriates credit for it, sometimes for a handsome fee. Furthermore, because the magic is brought into the situation, and leaves with the magician, the relationships between the people who are expected to enact the "solution" may well remain unchanged, leading to a high risk of failure and to the reinforcement of the idea that the problem is intractable (or the "client's" fault). If the "clients" involved are severely disadvantaged, as might be the case in the design of some social welfare or health services, this carries special significance. One of the challenges for our view of social innovation, then, is to reinvent our views of who does social innovation and how they relate to it (Garth, B. 2017).

How can LHA maximise the health benefits and mitigate risks of engagement.

- **How might LHA develop peer and support networks eroding boundaries between people with lived experience and professionals in the process?**
- **How might LHA measure benefits of collaboration for people involved in the process?**
- **How might LHA prepare people prior to the engagement to avoid potential harms during the process?**
- **How might LHA effectively manage power imbalances throughout the process?**

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