Co-leadership to co-design in mental health-care ecosystems: what does it mean to us?

Alan Rosen
Australian Health Services Research Institute [AHSRI], University of Wollongong, Wollongong, Australia and Brain & Mind Centre [BMC], University of Sydney, Camperdown, Australia, and

Douglas John Holmes
Department of Marketing and Communications, Global Engagement and Partnerships Division, The University of Newcastle, Callaghan, Australia

Received 11 June 2022
Revised 11 August 2022
Accepted 17 August 2022

Abstract

Purpose – This study aims to demonstrate how service providers, service users and their families should be able to share the co-leadership, co-auspicing, co-ownership, and co-governance, of a the mental health-care ecosystem, at every level, as it develops upwards and wider, in a process of inclusivity, conviviality and polyphonic discourse, via the overlapping phases of co-creativity, codesign, co-production, co-delivery, co-evaluation, co-research and co-replication, to achieve outcomes of co-communal or organisational well-being.

Design/methodology/approach – "Co-design" is shorthand code for encouraging multiple pathways and trajectories toward forming and sustaining a sparkling web or vibrant network of inclusive opportunities for stakeholder participation and a collaborative partnership in organizational development, in these circumstances, for more effective mental health services (MHSs).

Findings – In a co-design framework, all partners should be entitled to expect and "to have and to hold" an ongoing equal stake, voice and power in the discourse from start to finish, in a bottom-up process which is fostered by an interdisciplinary leadership group, providing the strong foundation or nutrient-rich and well-watered soil and support from which a shared endeavor can grow, blossom and generate the desired fruit in ample quality and quantity.

Originality/value – The authors should be working toward co-design and co-production of contemporary MHSs in a mental health-care ecosystem.

Keywords Total quality management, Mental health, Decision-making, Consumers, Leadership, Attitudes

Paper type Viewpoint

Introduction: top-down versus bottom-up reform

For too long, "reform" of mental health services (MHSs) in Australia has been piecemeal and fragmentary, and largely imposed from above by different levels of government on consumers, their families and service providers. Consultation of all main stakeholders has been intermittent and erratic at best, and virtually missing at crucial points. Managerial, commercial, empire building and bureaucratic interests and powerful clinical monocultures, whether public, non government organisation (NGO) or private, have had undue dominant influence on the shape of these developments.

Happell and Scholz (2018) clearly articulate the expectation that consumers should and will be involved in all aspects of MHSs. "Consumer leadership has been demonstrated to be beneficial to mental health services. Some of the barriers to implementation have limited the

Leadership in Health Services
Vol. 36 No. 1, 2023
pp. 59-76

1751-1879
DOI 10.1108/LHS-06-2022-0065

realization of this goal". World Health Organization (WHO) have identified the six barriers including whether funds are allocated to all stakeholders' groups, particularly if there is a power imbalance. They claim that:

> [. . .] allies do not intentionally or otherwise encroach on consumer knowledge and expertise, so that they maintain the important position of supporting consumers and facilitating the valuing and use of consumer knowledge, expertise, and ultimately, leadership.

Russo *et al.*'s (2018) response to Happell and Scholz (2018) highlights the difficulties of trying to develop a common language (and more cooperative conventions, we would add) with allies and others trying to develop this new system for the future.

The balance of this paper explores some of the terminology being used in the development of a new system of co-design that includes all stakeholders affected (Table 1).

Schneider (1986) observed in a critical review of a book called *The Triumph of Politics* by David Stockman, excusing himself from his direct involvement in the economic failures of the Reagan era, that "anyone who is fond of sausages and legislation", it has been said, "should not watch either of them being made".

> Australian Governments politicise their attempts at health service reform so much that they often turn out to be an unworkable mess or uncoordinated tangle of fragmented services, sometimes duplicating each-other, and failing to plan or work together. This is as if Governments have "a reverse sausage machine" which starts with a well-formed sausage at one end and produces a limp pile of mince at the other, leaving it to service providers on the ground to pick up the randomly spat-out bits and desperately fashion them into a vaguely useful system of care, which may provide some rough semblance of a service. It sometimes seems like governments are embarking on an absurdist enterprise, finely mincing a good steak in the attempt to reconstitute and recreate a facsimile of a fairly ordinary soya bean. (Rosen, 2013, pp. 234–235)

Now, more service providers are beginning to realize that bottom-up and top-down approaches need to meet often for the best results. Bottom-up innovation may generate and test the most improved solutions, but top-down authority may be needed ultimately to

Co-design [2]	Co-production [3]	Co-delivery [4]	Co-research [5]	Co-leadership [6]
. . . is a design approach that actively involves users and stakeholders from the beginning of a project, right through to roll-out. It means we work together, collaborating with everyone who has an interest to solve real problems, That is "working with" them	. . . is a relationship where professionals and citizens share power to plan and deliver support together, recognising that both have vital contributions to make in order to improve quality of life for people and communities.	. . . of public services is about citizens and the public sector working TOGETHER in new creative, innovative and collaborative ways	Co-research establishes a dialectical process of enquiry by drawing on the. complementary perspectives, interests, skills, and knowledge bases of academics. and practitioners	Co-leadership is two or more people in charge of a team or group. They share ownership of the goals of their team but divide the roles and responsibilities

Table 1.
Co-definitions for working together

Note: This table samples some common definitions for terms used in this paper;

ensure widespread dissemination. To some, Bottom-Up implies chaotic or even anarchic energies, whereas to others, Top-Down may be anathema because they are allergic to structure. We need an optimal balance between them both (Rosen, 1999, 2016), synergizing creativity, playfulness and freewheeling brainstorming with taking adult responsibility and accountability to ensure a reliable and effective product. However, taking responsibility and ownership on the ground then requires bottom-up appreciation, commitment, passion, collaboration and enterprise (Rosen, 2000).

Tindall (2021) in her recent cross-sectional review of the Australian MHS system, including the 2020 Productivity Commission Report on "best buys" for National MHSs and the 2021 Royal Commission into Victoria's MHSs, have caused government and the service system to more deeply consider how mental health care is designed and delivered. One of the overarching themes of the Royal Commission was that the system is inherently broken, requiring wide-reaching reform (State of Victoria, 2021). Specifically, the importance of learning with people who have first-hand experience "on the receiving end" of the usual application of the system has become increasingly apparent and valued. This has the potential to substantially improve the suitability, acceptability and credibility of MHSs.

Some previous attempts with co-design can be traced back to Sherry Arnstein (1969) in the USA. This is an example of what we are currently trying to do in Australia with this thing called co-design. The image is a ladder with the different levels of participation (Figure 1).

The Australian Government made a good start in 1992 with co-design when they produced The National Mental Health Strategy (Whiteford *et al.*, 2002) with a 20-year plan to improve how Mental Health Services were delivered. This included several strategies to involve consumers and carers at all levels of the system. However, from its second plan, it lost attached incentive funding, and subsequently its influence and momentum (Rosen *et al.*, 2012).

Unfortunately, the Consumer Participation manual (World Health Organization, 1993), British Columbia project in their report highlighted the six Barriers and Solutions (see Table 2) that would need be to be addressed before a co-design process could take place. Some Australian states have really dragged their feet in addressing those barriers.

The Kit: A Guide to The Advocacy We Choose to Do, (SPICE Consulting 1998). This resource was a product of the Community Development Project that aimed to enhance community sector advocacy and embed the role of consumers and carers in the mental health system.

What is co-design?

In Holmes (2016) report of the two workshops held in Melbourne and Sydney with consumers and carers and various other stakeholders accepted the definition from (*In This Together: Building Knowledge about Co-Production*):

> Designing and delivering services and systems in an equal and reciprocal relationship among professionals, people using services, their families and their community.

What is co-production?

As summarized by Ridente and Mezzina (2016), "Co-production" is a term coined in the USA by 2009 Nobel Prize winner in economics Ostrom and Baugh (1973):

> Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbors. After Boyle and Harris

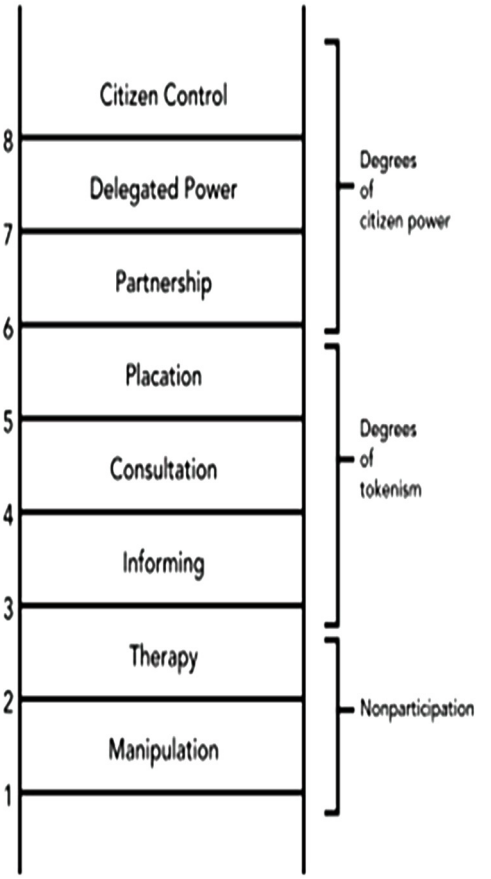

Figure 1.
Arnstein's ladder of participation (1969)

(2009), they state that where activities are co-produced in this way, both services and neighborhoods become far more effective agents of change.

It implies recognizing people as assets (which we would add is not intended to objectify people as chattels). However, like social capital, such assets characterizing a person should be honoured and the person may choose to share them with an organization, network or community, or not. Sharing these qualities may promote reciprocity, giving and receiving (trust between people and mutual respect) and building social networks, because a substantial proportion of the physical and mental well-being of people depend on enduring relationships built on such reciprocity.

What is co-delivery?

Webb *et al.* (2021) defined co-delivery of public services as entailing citizens and the public sector working *together* in new creative, innovative and collaborative ways. This joint working between professionals and service users, building on each other's assets, experiences and expertise, enables the service to be delivered more efficiently.

Barriers	Solutions
Barrier 1 – Money Consumers are not able to afford to participate. Expenses that are typically incurred when consumers participate include travel, meals, accommodation, incidentals, communications (telephone and mailing, and facsimiles if appropriate)	*Solution 1 – Up-front payment* Sufficient moneys should be budgeted to cover expenses incurred by consumers in policy work. • Money should be provided to consumers in advance for such fundamental necessities as travel and accommodation
Barrier 2 – Lack of information Consumers are usually not familiar with how committees are structured and how they work. Information that is critical includes terms of reference, background of committee members, rules of order, reporting structure of the committee, knowledge of who struck the committee, etc	*Solution 2 – Planned preparation* • Consumer participants should, well in advance, be provided with background material on all aspects of the project or committee with which they will be involved. This could include background papers, policy statements, etc. • Consumers can benefit from brief pretraining courses that focus on the skills needed to effectively participate in committee
Barrier 3 – Process Consumers are often disadvantaged in terms of participating in the committee discussions. They often find it difficult to jump into unstructured debate, tend to focus on specific problems rather than global systems problems, may not understand bureaucratic "bafflegab", are intimidated by "high-powered" committee members	*Solution 3 – User-friendly meetings* Committee can adopt procedures that make it easier for consumers to participate. Formally "going around the table" using Delphi or similar procedures make it more likely • that consumers will participate and • that participation will be more focused and relevant
Barrier 4 – Representation A system does not exist for nominating consumers to committee. Consumers who have managed to become visible, for whatever reason, tend to participate while the majority are excluded. Consequently, there may be questions about representativeness that restrict the weight given to consumer opinion	*Solution 4 – Resource pool* Consumers should be given support for developing a pool of available consumer participants, and service providers should use this pool to identify consumer representatives
Barrier 5 – Role There may not be a specific rationale for including consumers in the structure of the committee or other decision-making body. The agency or group, in consequence, may not have a clear idea of the role that the consumer is to play. Consumers, by the same token, may be unsure of their role and unable to provide focused input	*Solution 5 – Proper terms of reference* The terms of reference for the committee or agency should explicitly identify and clarify the role of the consumer
Barrier 6 – Isolation Consumer participation in some situations consists of one consumer among a group of professional health care providers. This is a situation in which consumers are disadvantaged and usually intimidated	*Solution 6 – Expanded participation* Assure that consumer participation will include at least two individuals, and provide means for these consumers to interact outside of the meeting place as well as at the meeting

Table 2.
Barriers and solutions WHO

Loeffler and Bovaird (2016) argue that co-production is a better term to use than using co-delivery. They explore some of the key claims made to use co-production [1] which are examined, and an assessment is made of how they stack up against the empirical evidence. Some areas are identified about which practitioners should be cautious

concerning the potential contribution of co-production, and where further research is needed.

What is co-researching?

Hartley and Benington (2000) describe an innovative methodology based on inter-organizational collaboration between academics and practitioners, using a "co-research" method that builds on but goes beyond the methodology of insider/outsider research teams. Co-research establishes a dialectical process of enquiry by drawing on the complementary perspectives, interests, skills and knowledge bases of academics and practitioners.

Hartley *et al.* argue that co-research is based on a triad of research roles. First, the academic responsible for the research, who manages the research team and who contributes an "outsider" view of the organization. Second, the host manager employed by the organization being researched. This person brings an "insider" perspective on the organization. Third, the co-researcher from a different organization who carries out the research alongside the academic(s). He or she is an "insider" in that they are familiar with the type of organization being researched, but an "outsider" in that their own organization has a different context and processes.

In consumer-enabled mental health research, another layer, construction and dimension of "insider" and "outsider," becomes possible with "insider" denoting consumer lived experience.

The research paradigm is one of knowledge generation through a negotiated and dialectical approach to organizational processes.

What is co-leadership?

Co-design connects with co-leadership practically through the development of a leadership group, and this entails synergizing the input into leadership to ensure inputs from several expert viewpoints and all key stakeholders' perspectives, to provide support and company for what otherwise would be a very lonely and isolating job, and to role model and explicitly value a co-design model appropriate for that organization.

Before we start discussing co-leadership, we need to talk about leadership and the different leadership styles using Harvard Business Schools (Harvard Leadership Styles: Six Leadership Strategies, 2022) (Table 3).

Coercive	Pacesetting	Coaching	Democratic	Affiliative	Authoritative
This is a leader who demands immediate compliance. The phrase most descriptive of this leader is: "Do what I tell you!"	This is a leader who sets extremely high standards for performance. The phrase most descriptive of this leader is: "Do as I do, now!"	The coach is a leader who focuses on developing people for the future. The phrase most descriptive of this leader is: "Try this."	The democratic leader achieves consensus through participation. The phrase most descriptive of this leader is: "What do you think?"	An affiliative leader wants to creating harmony and build emotional bonds with employees. The phrase most descriptive of this leader is: "People come first."	The authoritative leader mobilizes people with enthusiasm and a clear vision . . . The phrase most descriptive of this leader is: "Come with me."

Table 3.
Leadership definitions from Harvard business school

Six leadership styles

The six leadership styles, in order of their impact on an organizational culture, are briefly discussed below.

(1) Coercive

This authoritarian or dictatorial style can destroy an organization's culture. This is because the downside is far greater than the upside. Therefore, a coercive style should only be used with extreme caution. It is useful in an emergency and may work in a crisis. In addition, it can help in a "turn-around" situation or as a last resort with a problematic employee.

The coercive leadership style has the most negative impact (−0.26) on the overall organizational culture.

(2) Pacesetting

A pacesetting style can destroy a good culture. It only works with a highly motivated and competent team who are able to, essentially, read the leader's mind. Others will feel overwhelmed and give up. This is because they cannot see themselves meeting the leader's standards.

The pacesetter has virtually the same negative impact (−0.25) on the overall organizational culture as a coercive leader. This style particularly has an impact by providing rewards and commitment.

(3) Coaching

Coaching leaders are great delegators. They are also willing to put up with short-term failures, provided they lead to long-term development. This style works best when you want to help employees improve their performance or develop their long-term strengths.

The coach has a positive impact (0.42) on the overall organizational culture.

(4) Democratic

This style builds trust, as well as respect and commitment. Furthermore, it works best when you want to receive input or get employees to "buy-in" or achieve consensus. It does not work under severe time constraints or if employees are confused or uninformed.

If handled correctly, this style has a positive impact (0.43) on the overall organizational culture.

(5) Affiliative

This relational style works best when you want to motivate employees. This is especially true when they face stressful situations. In addition, this style works well when you want build team harmony, improve communication, increase morale or repair broken trust.

An affiliative leader has a positive impact (0.46) on the overall organizational culture. This style has virtually no downside, and therefore it is often seen as the best overall approach.

(6) Authoritative

This style works best when change requires a new vision or when employees are looking for a new direction. However, this style fails when employees are more knowledgeable or experienced than the leader, or if the authoritative style becomes intrusive and overbearing. Provided that it is used with finesse, this style has the most positive impact (0.54) on the overall organizational culture.

The research found that the best leaders master four or more styles, especially the authoritative, affiliative, democratic and coaching styles. Leaders who can move seamlessly from one to the other, depending on the situation, produce the most positive organizational cultures and enjoy the greatest business successes.

Klinga, *et al.* (2016) describes co-leadership as one approach to meet the managerial challenges of integrated services, but research on the topic is limited. Alakeson and Perkins (2012) states that co-leadership is two or more people in charge of a team or group. They share ownership of the goals of their team but divide the roles and responsibilities.

Wilbur and Orville Wright worked together to invent the first successful airplane. Trey Parker and Matt Stone used their creative talents to come up with the irreverent animated series, *South Park*, one of the longest-running television shows in America. Ben Cohen and Jerry Greenfield, founders of Ben & Jerry's Ice Cream, got started by taking a $5 ice cream course together.

When you think of leadership, it is easy to think about one person steering the ship. But, as the above examples prove, there are plenty of successful creations that have two or more people at the helm.

That's co-leadership in action. And, while it might seem counterintuitive to your traditional view of authority, these types of partnerships can really pay off.

In some Community Mental Health teams, affiliative, coaching or participatory democracy led interdisciplinary teams often prevail, with an everyday informal horizontally flattened hierarchy But when a crisis or emergency is in play, a much more vertical leadership structure rises almost instantly, in which everyone should know their place and role (see "Flattening the Working Hierarchy" section).

It is useful to have an ongoing co-leadership team rather than a lonely sole leader, so the leadership group can be a constant source of reciprocal advice and human support, with differentiated roles and continuous sampling and input from the constituencies of each leader (Rosen, 1998; Rosen and Callaly, 2005). This leadership model should combine professional and peer worker, as well as clinical and academic expertise at every level, from direct service or project teams to senior management. The reforms implementing the findings of the Royal Commission in the Australian State of Victoria, including the legislative charter of the Victorian Collaborative Centre of Mental Health are currently attempting to adopt such a model (Byrne and Wykes, 2020; Jones *et al.*, 2021). Consultation – understood as predominantly unidirectional, often one-off activities designed to gather stakeholder input or feedback – is not a substitute for direct involvement and leadership of persons with lived experience in project decision-making (Jones *et al.*, 2021). People who happen to have a lived experience can be distinguished from, and also can evolve into those who learn how to view services and research "from a lived experience perspective, and why that matters." Employing them to co-lead at every level can generate better outcomes: they "provide a common-sense, firsthand understanding and approach to surviving and thriving with mental health challenges" (Byrne and Wykes, 2020).

Recently, the World Health Organization (2015) proposed that distributed leadership between multiple actors who work together across professional and organizational boundaries is one key to achieving people-centered and integrated health services

Working together

Bringing co-design, co-production, co-delivery, co-research and co-leadership together means not only designing the services together from the ground up, but also fully developing, piloting, evaluating, implementing, disseminating and sustaining together. No longer just gestural or occasional consultation, but active participation at every stage. From

conception to realization and sustaining stages. It is participatory democracy in action. For an enduring service development must make sense to all who need it as well as all who work within it. Only being engaged or involved at the implementation or delivery phase will not generate genuine ownership or taking of real responsibility for the work plan.

Working together for both commissioning and de-commissioning

To begin with this means co-operative mapping of what works, what are the gaps and scanning both research and experiential narrative accounts for the evidence for what additional or alternative services that we need.

It means not only co-commissioning missing components of and gaps in "what works": that is, what interventions and service delivery systems have been shown to work well and reliably. But, at the same time, we need to have the joint authority to collaboratively de-commission what does not work well. To do this, we need to be able to identify not only met need (treated prevalence) or unmet need (untreated prevalence) but also met un-need (treated non-prevalence) (Rosen, 1999; Bobevski *et al.*, 2017). We need to be able to demonstrate what functions and structures are habitual but ineffective or unnecessary (met un-need), which therefore can be dispensed with, so we can flexibly free up the resources deployed for much more needed (unmet need) and effective strategies.

Combining different expertise(s)

Co-design, co-production, co-delivery, co-research and co-leadership entail working together to develop services that work well, in terms of rigorous research evidence of good outcome, clinical experience, and especially in terms of acceptability to and desirability by individuals and families with lived experience of mental illnesses. We achieve this by mobilizing and marshalling different experts to work together. This confluence of expertise, like three streams forming a powerful river, combines and synergies academic, clinical and lived experience types of expertise.

These services must tick the boxes of being academically strongly evidence based and clinically best practice or promising, but also must provide a good "fit" in terms of what service users and families with their particular aspirations and expertise, know that they will find useful, practical, growth-inducing, congenial and convivial (Illich, 1973). Conviviality entails developing, deploying and exerting our control over tools for convivial living or "eutropelia" (mobilizing the power of serious, graceful and creative playfulness) (von Rahner, 1965) in the service of developing deeper and more cooperative personal relations. We should do this rather than treating humans as interchangeable cogs, allowing mass production of machines to dominate and enslave humans, to monopolize our time and consciousness, and turn us all into mere consumers of technical products (Illich, 1973).

How can we arrive collaboratively at workable multifaceted solutions for complex open systems?

Expert-enhanced cooperative complex human systems analysis involves each of these types of academic and experiential expert being prepared to appraise the pattern of data or results from the vantage point or lens of their particular vast experience, which informs their judgment and intuition (Gibert *et al.*, 2010). Mobilizing implicit knowledge and expertise, as well as explicit, easily accessible knowledge (e.g. data sets) involves processes familiar to those who work with both qualitative and quantitative research, neural networks and humane and ethically responsible applications of artificial intelligence.

The inclusion and appraisal of all these multifaceted components all contribute to an "open systems" approach, enabling the person and their network to disrupt repetitive

habitual "closed system" thinking about a problem in their network, by including new promising external inputs and viewpoints into the system via a much wider social network or Social Systems Intervention (Bridgett and Polak, 2003a, 2003b) or Open Dialogue techniques (Seikkula *et al.*, 2006), which require further rigorous research. Several overlapping networks may be involved in the often-interacting problems of persons, families or communities (Bridgett and Polak, 2003a and 2003b).

Working at both micro and macro systems levels

Co-design and co-leadership should be required at every level of the MHS organization, from nano, to micro, to meso, to macro (Rosen *et al.*, 2020; Byrne and Wykes, 2020; Thornicroft and Tansella, 2001, 2006).

At the micro level, co-design, co-production, co-delivery, co-research and co-leadership mean that clinical professionals, support workers, as well as consumer and carer. Aboriginal and transcultural peer professionals must be able to work together toward common purposes for and with particular individuals, families and groups.

Again, at the microlevel, all these service providers should be working together on personalized wellness and recovery plans, co-produced and reviewed with individual consumers, their families and support teams.

Simultaneously, at the macrolevel, they should be designing and delivering highly integrated wholistic services, working to a single framework that represents the cooperative development of one unitary strategic mental health plan for that region, combining public, NGO and private fee-for-service interests. Co-leadership is both essential and desirable at all levels from nano to macro, [or interpersonal, clinical, organizational and cultural – e.g. Indigenous mental health – Chandler and Lalonde (2006)], where inclusion of Indigenous co-leadership and staffing at all levels of community agencies can be shown to contribute to lowering suicide rates in young indigenous people – and e.g. socio-politically, co-leadership should ensure facilitation of the Human Rights agenda, with reference to United Nations Convention on the Rights of Persons with Disabilities and the WHO Quality Rights program (Mezzina *et al.*, 2018).

One powerful example at the microlevel, supported by the macro regional mental health directorate, has been the completion of deinstitutionalization in Trieste by providing a wide range of community based supported housing together with residential rehabilitation services for the most severely disabled MHS users who were among the last to leave the former psychiatric hospital site in 2015. This institution, like others in Italy, had been closed to new admissions since the National Law of 1978 and closed altogether following a second law of 1998 applying a tax penalty to provinces that failed to comply. These housing options are managed by local social cooperatives (not-for-profit social firms). This was achieved through implementation of a personal health and support budget for each service user to use with the support of their families, as a form of co-production (Ridente and Mezzina, 2016). These authors draw on a British definition, related to that of our National Disability Scheme, of a personal budget as:

> An allocation of social care or [health] resources or an integrated allocation of both that is controlled by an individual and can be used to meet identified goals. Personal Budgets and Personal Health Budgets give individuals and their family carers greater say over how their health and social care needs are met. They do this by transferring control of public resources to individuals (who can then choose their own rehabilitative support services) rather than having the state commission services on their behalf. (Alakeson and Perkins, 2012, p. 3)

Provided that this program does not result in the mere payment of a "voucher" that allows individuals to "buy" public or private services unilaterally, it represents a form of

"co-production" with personalized service planning between service users, service brokers and providers (Ridente and Mezzina, 2016). It may not provide all service needs for everybody, and some core services may need to be block-funded to ensure stable continuity of essential evidence-based components of care.

Flattening the working hierarchy: from co-delivery to co-research

A co-design, co-production, co-delivery, co-research and co-leadership trifecta means not working at cross purposes, and not having some stakeholder groups (e.g. providers) dominating others (e.g. service-users and carers), effectively saying to all the others: "we know what's best for you." This is known as the presumption of "Vocational Ownership" of a stakeholder group (e.g. service users) by another more dominant stakeholder group (e.g. clinician providers) (Thornicroft G, pers comm. 2000).

Co-design, co-production and co-delivery entail working in partnership. Partnerships work best when they are between parties who are equals. Equals in status, respect and in power. We have a long way to go in these respects. But we are at least have turned the first corner and are on the road, near the beginning of a new long journey together.

Hierarchies need to be flexible in an MHS organization that has to deal with both human emergencies and family crises, as well as routine tasks with continuity of care and monitoring, in the context of low key engagement, informal relating and generating trust toward developing a strong therapeutic alliance. For everyday purposes, a flattened hierarchy works best. Interdisciplinary relationships within teams and between service users and providers can and should be quite informal, egalitarian and collaborative, "shoulder to shoulder."

However, in life-threatening emergencies, everyone needs to know their role and place, so the hierarchy may temporarily rise like a waterspout out of an otherwise placid lake. Vertical hierarchies, like waterspouts, require a lot of energy and diverted concentration to maintain, so should only be allowed to rise for the shortest possible periods. Even when the vertical hierarchy has necessarily risen, e.g. in dealing with an individual, family, communal or organizational emergency, there is no excuse for disrespect, discourtesy or abuse either way between provider roles at different levels of authority and responsibility, or between providers and service users. Even in potentially or actually fraught situations, a brief timeout should be taken to consider alternative approaches, if possible, by all key team members. This could include consulting an experienced supervisor/coach, or a nearby peer worker, Transcultural or Indigenous mental health worker who knows the service user, family and their community well, or who has had the opportunity to assess them thoroughly, to consider whether there are still viable and as yet unconsidered alternatives to involuntary hospitalization, and a way of de-escalating the mounting crisis that led to tipping it into being redefined as an apparent life-threatening emergency (Rosen, 2018). Co-design between service users and providers, bouncing meaning off or co-researching these experiences, can make these episodes and transitions briefer, much safer, more effective and much less traumatic. For example, research studies of how to minimize seclusion and restraint by involving service users' expertise in reviewing every instance that they are proposed or deployed and suggesting and trying practical alternatives and then systematizing them as candidate solutions (Foxlewin B, pers comm. 2015).

It is becoming more widely accepted that many more consumers or lived experience co-researchers should be well trained in either or both participatory qualitative and quantitative research, and be part of every mental health research team, as evidenced by research funding bodies increasingly requiring peer service user and/or family involvement as research co-investigators. Invoking "Stand-point Theory," the epistemic weights of different mental health stakeholder groups vary widely. Highest weights are attributed to payers and health and medication industry executives, senior medical clinicians, high-level administrators and PhD-level

researchers, while lower weights may be assigned to peers, paraprofessionals, bachelor to masters level clinicians and researchers. Iterative consensus-seeking decision-making methods (not just imposing dominant class majority rule) between stakeholder groups in different positions in the power hierarchy, e.g. about MHS priorities, and service-user-centered design and participatory research amplifying more stakeholder voices can enrich scope and validity of research findings (Jones, 2018).

Co-design and co-leadership with consumers who have lived experience of mental ill-health Voorberg *et al.*'s (2015) Systematic Review highlighted the importance that policymakers attach to citizen engagement in social innovation, we aim to provide a more evidence-based overview regarding the conditions under which citizens co-create or co-produce. Second, the choice for a systematic review helps to make the current body of knowledge more transparent in a reproducible way.

Waging peace

The last book of internationally acclaimed Australian commentator, author, filmmaker, broadcaster, mental health lived experience and family advocate Anne Deveson (2013) was on this topic, whether talking of trying to bury the hatchet at the local network or geo-political global level. She argued that if we waged peace with all the passion and resources that we usually wage war among ourselves, outstanding conflicts and rifts could be healed, and we could work much more fruitfully together toward meeting urgent outstanding needs.

Co-design and co-production mean not having a widening gulf between the main aims and goals of consumers and families on one hand, and government, managers and clinicians on the other, or between community-oriented and hospital-bound clinicians and advocates. We do not need multiple MHS cultures, too often at war with each other:

> Some traditional fortress-hospital based clinicians argue that rigorous studies of mental health reforms are tainted with a marked ideological component. As such, they are deemed extremely dependent on charismatic leaders, who are especially vulnerable, given leadership changes and the political powers on which they depend. However rigorous the positive findings of pioneering studies and however many successful replications of community reform results there may be, such researchers often are the targets of downgrading or dismissing of the significance of their positive results. These results have been ascribed variously to enthusiasm, charisma evangelical or religious fervour, and ideological fixation, rather than to their scientific outcomes. However, there is no monopoly on ideology: institutionally centred services have been defended on the basis of ideology and without evidence for several centuries. Similarly, there remains an evidence-free reactionary zone defended by a vocal minority of hospital-based clinicians arguing against a shift towards community care. Furthermore, some pioneers of community-oriented and lived experience and family-centric mental health services state that they were never characterized as charismatic until they succeeded in producing and replicating strong evidence of improved outcomes . They would prefer that their reforms be judged not on their theories but on their practical results. (Rosen, 2013, pp. 236–237)

Instead, we need one well-functioning and cohesive community of mental health stakeholders, working closely together. Mental health is a serious endeavor, sometimes life or death stuff. Finding a way to work together effectively is a matter of urgency. We all have a responsibility to engage each other in working alliances, rather than indulge ourselves in endless ideological battles. Co-design and co-production methodology provides us all with a key to the door that we all need to go through together to find this common space.

There will always be a backlash to contend with, but more importantly it is likely to be composed in part of initially skeptical good people wanting to do their best. They may be misinformed service users and families, defensive habitual practitioners out of their comfort zone or just reflective and cautious slow-adopters who we need to engage more effectively.

Engaging all stakeholders is such important work. It is a crucial part of social inclusion. It will challenge our patience, our inclusivity, our empathy and our creativity to be able to do so, but it is essential that we try to do it and largely succeed by persevering over time.

Widening both the social inclusion and the common ground

Co-design, co-production, co-delivery, co-research and co-leadership mean building together and operationalizing a shared vision, with a common mental map of our MHS, which inspires and makes sense to all participants, forming an ever-evolving learning organization, learning in teams and inclusive ongoing communities of practice with all service users and providers. Co-design, co-production, co-delivery, co-research and co-leadership mean, when working together from diverse team roles and standpoints, finding and widening the most common ground, we can all stand on and occupy together at the same time (Senge, 1990).

Conclusion

The co-design framework for a contemporary MHS could be based on a Mental Healthcare Ecosystem model. The model metaphorically and pictorially resembles a planter box, flower pot or a cup pf tea. A flower pot or planter box model of leadership and management inverts the usual hierarchy diagram to place leadership at the bottom, providing the soil and support with adequate nutrients and regular watering to nurture and enable the emerging flowers reaching above the rim (the service providers and consumers at the work interface) to blossom, flourish and seed the next generations of both. Equally, another dimension of this model could start at the bottom of the flower pot from nano- and microlevel individual and family interventions and service delivery systems, to meso- and macrolevel interventions and service delivery systems for the well-being, mental illness prevention, early intervention and care for an entire community or regional catchment population. Co-leadership and co-design should be required at every level of the MHS organization, from nano, to micro, meso and to macro (Rosen *et al.*, 2020; Byrne and Wykes, 2020; Thornicroft and Tansella, 2001, 2006) (see Figure 2). Because this framework also roughly resembles a cup of tea, it does so to remind us that while much current evidence-based interventions end with the letter "T" (CBT, DBT, NCRT, IPT, CAT, etc.) , one key "T-term" does not. It is the

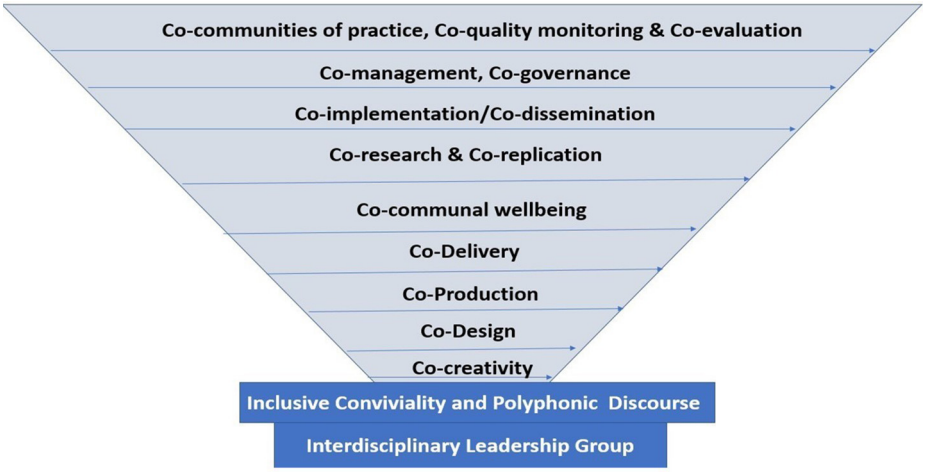

Figure 2.
Co-design framework for mental health service ecosystems: a flowerpot or a cup of tea with saucer?

"cup of tea' that you may receive to make you feel welcome and to help you settle down, relax a bit and feel free to tell your story if you wish. It is not a formal intervention, but represents the quality of the initial and ongoing engagement of the service delivery system. For the purposes of co-leadership and co-design, we will focus on the complex layers of how we could fruitfully work together (see Figure 2).

Co-leadership is the foundation of all the subsequent layers, and it starts and ends with sustaining inclusive continual discourse and checking back with the community of MHS stakeholders. Inclusive consultation follows, entailing "polyphonic" discourse (Seikkula *et al.*, 2006), where all voices are respectfully listened to, encouraging co-creative problem-solving while accessing the wider vibrant community of those with a stake in MHS's, then leading to the grind of task groups taking on co-design, co-production and developing co-delivery systems. Co-communal well-being reminds us that in a co-endeavor context, both service users and providers are entitled to pastoral support for their personal and family well-being. Rigorous co-research and co-replication come next, and if successful, then co-implementation and widespread co-dissemination, which entails highly organized co-management and co-governance systems. Co-quality (e.g. clinical and support standards and fidelity criteria) monitoring, co-evaluation methods (e.g. Yes, Satisfaction Survey, Functional and Recovery measures, Indigenous indicators of Social and Emotional Well-Being) and co-communities of practice are then routinely applied, further widening the community involved. This bottom-up process is iterative, repeatedly returning from bottom to top, doing the whole sequence again with every new cycle of reform, new adaptation or evidence-based initiative. A truly co-designed mental health-care ecosystem should be an open-ended, living, breathing, growing and evolving convivial process resulting in a reliably helpful and enduring product, from the experience of all its co-designers, who are often simultaneously both providers and receivers of benefit.

Leadership: Does Your Vehicle Have Charismatic Transmission? Initially, the person with a new vision may be a lone voice but this can become increasingly lonely over time and does not in itself translate into an enduring system:

> Vision is only productive when the initial holder of the vision finds a way to share it. If innovation principally relies on charismatic transmission, it will not survive after the charismatic leader moves on or the fashion passes. For a health or clinical reform move- ment to take hold, prevail, persist, and gather further momentum in the long term, it must attract and consolidate a broad leadership group with an agenda based on sound evidence, demonstrable skills, and experience. Ironically, the very person who is persuasive and dynamic enough to precipitate change may inadvertently interfere with a broadening of the leadership base. Through force of personality and centrality to the initial change process, the charismatic leader can so dominate the leadership of the project that there is little room for other potential leaders to develop and be available when needed. Some leaders are extremely effective as initial change agents, and go from one system to another starting new projects and developing new services. Other leaders have the inclination and skills to stay with one service over the long haul, growing with the service and helping to develop a broad base of future leaders. Occasionally both sets of qualities may be found in the same person(s). Whatever the situation, a broad leadership group, long-distance determination and tenacity are required to transform mental health services innovation into a stable system of care. (Rosen *et al.*, 1997, pp. 29–30).

The eminent London School of Economics (LSE) UK health economist Richard Lord Layard (Layard and Clark, 2014) in being asked by then British Prime Minister Gordon Brown to design innovations to consistently fill gaps in the National Health Service primary health counseling and psychotherapy service systems, appraised the MHS system as being at its most cost-effective when it played to its greatest strength: sound teamwork.

Our conviction is that an MHS needs to have a culture of sound, well-trained, well-supervised and well-supported, reliable team players in inclusive, interdisciplinary teams, at every level, from interface with the public to service leadership and back again.

Just as we need sound interdisciplinary teamwork with a rich mix of up-to-date skills and complementary experience, and a well-honed and calibrated division of labor to operate evidence-based interventions and service delivery systems, we need leadership teams of similar strengths, diversity of experience, integration and capacity for reciprocal support.

Co-design, co-production, co-delivery, co-research and co-leadership, at every level, are the keys to both.

Note

1. This need to be made clearer.
2. Available at: https://defrafarming.blog.gov.uk/2020/12/11/what-we-mean-by-co-design/
3. Available at: https://leedscitylab.wordpress.com/what-is-co-production/
4. Available at: www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp1112/12rp01
5. Available at: www.tandfonline.com/doi/abs/10.1080/13594320050203085
6. Available at: www.imd.org/imd-reflections/reflection-page/leadership-styles/

References

Alakeson, V. and Perkins, R. (2012), "Recovery, personalisation and personal budgets", Centre for Mental Health, September 2012, Retrieved from Recovery, personalisation and personal budgets, Centre for Mental Health.

Arnstein, S.R. (1969), "A ladder of citizen participation", *Journal of the American Institute of Planners*, Vol. 35 No. 4, pp. 216-224, doi: 10.1080/01944366908977225.

Bobevski, I., Rosen, A. and Meadows, G. (2017), "Mental health service use and need for care of Australians without diagnoses of mental disorders: findings from a large epidemiological survey", *Epidemiology and Psychiatric Sciences*, Vol. 26 No. 6, pp. 1-11, doi: 10.1017/S2045796017000300.

Boyle, D. and Harris, M. (2009), "The challenge of co-production: how equal partnerships between professionals and the public are crucial to improving public services", Nef/NESTA, available at: www.nesta.org.uk

Bridgett, C. and Polak, P. (2003a), "Social systems intervention and crisis resolution", *Part 1: Assessment, Advances in Psychiatric Treatment*, Vol. 9, pp. 424-431.

Bridgett, C. and Polak, P. (2003b), "Social systems intervention and crisis resolution", *Part 2: Intervention, Advances in Psychiatric Treatment*, Vol. 9, pp. 432-438.

Byrne, L. and Wykes, T. (2020), "A role for lived experience mental health leadership in the age of Covid-19", *Journal of Mental Health*, Vol. 29 No. 3, pp. 243-246, doi: 10.1080/09638237.2020.1766002.

Chandler, M.J. and Lalonde, C.E. (2006), "Cultural continuity as a moderator of suicide risk among Canada's first nations", in Kirmayer, L. and Valaskakis, G. (Eds), *The Mental Health of Canadian Aboriginal Peoples: Transformations, Identity, and Community*, University of British Columbia Press, Vancouver.

Deveson, A. (2013), *Waging Peace: Reflections on Peace and War from an Unconventional Woman*, Allen and Unwin, Sydney.

Gibert, K., García-Alonso, C. and Salvador-Carulla, L. (2010), "Integrating clinicians, knowledge and data: expert-based cooperative analysis in healthcare decision support", *Health Research Policy and Systems*, Vol. 8 No. 1, p. 28, available at: www.health-policy-systems.com/content/8/1/28

Happell, B. and Scholz, B. (2018), "Doing what we can, but knowing our place: being an ally to promote consumer leadership in mental health", *International Journal of Mental Health Nursing*, Vol. 27 No. 1, pp. 440-447, doi: 10.1111/inm.12404.

Hartley, J. and Benington, J. (2000), "Co-research: a new methodology for new times", *European Journal of Work and Organizational Psychology*, Vol. 9 No. 4, pp. 463-476, doi: 10.1080/13594320050203085.

Harvard Leadership Styles: Six Leadership Strategies (2022), "Harvard leadership styles: six leadership strategies", viewed 28 April 2022, available at: www.corporatetraining.ie/harvard-leadership-styles/

Holmes, D. *et al.* (2016), "Shared perspectives on authentic co-design: putting consumers and carers at the centre of mental health reform", Co-Design Initiative, an independent voluntary project auspiced by Civil Society, Melbourne, available at: https://auspwn.files.wordpress.com/2016/05/codesign-shared-perspectives-report-vf1-5-040616.pdf

Illich, I. (1973), *Tools for Conviviality, CIDOC Centre for Intercultural Documentation*, Calder and Boyars, London.

In This Together Building knowledge about co-production (2011), "In this together building knowledge about co-production 2011", viewed 21 February 2022, available at: https://neweconomics.org/uploads/files/b3d00daf74d4c4411b_k1m6ibw57.pdf

Jones, N. (2018), "Beyond the clinic, or context matters, keynote address", *11th International Early Intervention in Psychiatry Conference*, Boston, available at: https://doi-org.ezproxy.newcastle.edu.au/10.1176/appi.ps.202000468

Jones, N., Atterbury, K., Byrne, L., Carras, M., Brown, M. and Phalen, P. (2021), "Lived experience, research leadership, and the transformation of mental health services: building a researcher pipeline", *Psychiatric Services*, Vol. 72 No. 5, pp. 591-593.

Klinga, C., Hansson, J., Hasson, H. and Sachs, M.A. (2016), "Co-leadership – a management solution for integrated health and social care", *International Journal of Integrated Care*, Vol. 16 No. 6, p. 7, doi: 10.5334/ijic.2236.

Layard, R. and Clark, D.L. (2014), *Thrive: The Power of Evidence Based Psychological Therapies*, Allen Lane, London.

Loeffler, E. and Bovaird, T. (2016), "User and community co-production of public services: what does the evidence tell us?", *International Journal of Public Administration*, Vol. 39 No. 13, pp. 1006-1019, doi: 10.1080/01900692.2016.1250559.

Mezzina, R., Rosen, A., Amering, M. and Javed, A. (2018), "The practice of freedom: human rights and the global mental health agenda", in Javed, A. and Fountoulakis, K.S. (Eds), *Advances in Psychiatry*, World Psychiatric Association, Springer, Cham, pp. 483-515.

Ostrom, E. and Baugh, W.H. (1973), Community Organization and the Provision of Police Services, Sage Publications, Beverly Hills, CA.

Ridente, P. and Mezzina, R. (2016), "From residential facilities to supported housing: the personal health budget model as a form of coproduction", *International Journal of Mental Health*, Vol. 45 No. 1, pp. 59-70.

Rosen, A. (1998), "Devening the role of the consultant psychiatrist in a public mental health service", *Australian and New Zealand Journal of Psychiatry*, Editorial Commentary on Tobin M and Boyce P, Defining the role of the consultant psychiatrist in a public mental health service. Vol. 32 No. 5, pp. 612-616.

Rosen, A. (1999), "Chapter on Australia: from colonial rivalries to a national mental health strategy", in Thornicroft, G. and Tansella, M. (Eds), *Reforming Mental Health Services: The Mental Health Reform Matrix*, Cambridge University Press, Cambridge.

Rosen, A. (2000), "Chapter on Australia: from colonial rivalries to a national mental health strategy", in Thornicroft, G. and Tansella, M. (Eds), *Reforming Mental Health Services: The Mental Health Reform Matrix*, Cambridge University Press, Cambridge.

Rosen, A. (2013), "Must try harder: Australia's half-hearted attempts at transition from hospital-centric to community-based mental health services", In Obsessive Hope Disorder, Perspectives Report, pp. 231-239.

Rosen, A. (2016), "What does co-design, co-production and co-delivery mean to me?", In: Co-design: shared perspectives in authentic co-design: the co-design initiative, Civil Society, Melbourne.

Rosen, A. (2018), "'The Doctor's Dilemma' revisited: how can we operationalise working 'Two Ways mental health services-combining the best of Western evidence-based psychiatric practices with optimal use of traditional healing practices for all indigenous communities?', *Symposium*, *World Psychiatric Association Congress*, *Santa Fe, Mexico*, *September*.

Rosen, A. and Callaly, T. (2005), "Interdisciplinary teamwork and leadership: issues for psychiatrists", *Australasian Psychiatry*, Vol. 13 No. 3, pp. 234-240.

Rosen, A., Diamond, R.J., Miller, V. and Stein, L.I. (1997), "Becoming real: from model programs to implemented services", in Hollingsworth, E.J. (Ed.), *The Successful Diffusion of Innovative Program Approaches, New Directions for Mental Health Services*, Vol. 74, Jossey-Bass, San Francisco.

Rosen, A., Gill, N.S. and Salvador-Carulla, L. (2020), "The future of community psychiatry and community mental health services", *Current Opinion in Psychiatry*, Vol. 33 No. 4, pp. 375-390, doi: 10.1097/YCO.0000000000000620, available at: https://protect-au.mimecast.com/s/dt8tCL7EwMfRmg5O8IBzGyu?domain=journals.lww.com

Rosen, A., O'Halloran, P. and Mezzina, R. (2012),"International trends in community mental health services", in McQuiston, H., Sowers, W.J. and Ranz Feldman, J. (Eds), *Handbook on Community Psychiatry*, , 2nd ed, Springer, New York, NY.

Russo, J., Beresford, P. and O'Hagan, M. (2018), "Commentary on: Happell, B. and Scholz, B (2018), Doing what we can but knowing our place: being an ally to promote consumer leadership in mental health", *International Journal of Mental Health Nursing*, Vol. 27 No. 6, pp. 440-447, *Int J Mental Health Nurse*, Vol. 27, pp. 1877-1878, doi: 10.1111/inm.12520 .

Schneider, W. (1986), "Review of stockman DA", The *Triumph of Politics*, Washington Post, Book World, April 27, Washington DC, p. 8.

Seikkula, J., Aaltonen, J., Alakare, B., Haarakangas, K., Keränen, J. and Lehtinen, K. (2006), "Five-year experience of first episode nonaffective psychosis in open-dialogue approach: treatment principles, follow-up outcomes, and two case studies", *Psychotherapy Research*, Vol. 16 No. 2, pp. 214-228, doi: 10.1080/10503300500268490.

Senge, P. (1990), *The Fifth Discipline: The Art and Practice of the Learning Organisation*, 2nd ed., 2006, Random House, New York, NY.

SPICE Consulting (1998), "This is the correct link for the Spice Consulting reference", available at: https://auspwn.files.wordpress.com/2014/05/austgov2009aguidetotheadvocacywechoosetodothekit.pdf

State of Victoria (2021), "Royal commission into victoria's mental health system", Victorian Government, February, Melbourne, Australia.

Thornicroft, G. and Tansella, M. (2001, 2006), "The mental health matrix: a manual to improve services", Cambridge University Press, Cambridge.

Tindall, R.M., Ferris, M., Townsend, M., Boschert, G. and Moylan, S. (2021), "A first-hand experience of co-design in mental health service design: opportunities, challenges, and lessons", *International Journal of Mental Health Nursing*, Vol. 30 No. 6, pp. 1693-1702, doi: 10.1111/inm.12925.

von Rahner, H. (1965), *Man at Play*, translated by Battershaw, B. and Quinn, E., Burns and Oates: A Compass Book, London.

Voorberg, W., H., Bekkers, M., Tummers,. and L., G. (2015), "A systematic review of co-creation and co-production: embarking on the social innovation journey", *Public Management Review*, Vol. 17 No. 9, pp. 1333-1357, doi: 10.1080/14719037.2014.930505.

Webb, D., Mallo, D., Tardiveau, A., Emmerson, C., Pardoe, M. and Talbot, M. (2021), "16: The containment of democratic innovation: reflections from two university collaborations", *In Hope under Neoliberal Austerity*, Policy Press, Bristol, available at: https://doi.org/10.51952/9781447356844.ch016 (accessed 3 September 2022).

Whiteford, H., Buckingham, B. and Manderscheid, R. (2002), "Australia's national mental health strategy", *British Journal of Psychiatry*, Vol. 180 No. 3, pp. 210-215, doi: 10.1192/bjp.180.3.210.

World Health Organisation (1993), "British Columbia project, consumer participation manual", viewed 10 May 2022, available at: https://auspwn.files.wordpress.com/2014/05/1993-consumer_participation_manual.pdf

World Health Organization (2015), "World HO global strategy on people-centred and integrated health services", available at: www.who.int/servicedeliverysafety/areas/people-centred-care/en/

Further reading

Atlassian The Workstream (2022), "The surprising benefits of co-leadership because two brains really are better than one", available at: www.atlassian.com/work-management/team-management-and-leadership/decision-making/co-leadership (accessed 9 April 2022).

Parks, R.B., Baker, P.C., Kiser, L., Oakerson, R., Ostrom, E., Ostrom, V., Percy, S.L., Vandivort, M.B., Whitaker, G.P. and Wilson, R. (1981), "Consumers as coproducers of public services: some economic and institutional considerations", *Policy Studies Journal*, Vol. 9 No. 7, pp. 1001-1011.

Resolution (2003) Part 1: Assessment, Advances in Psychiatric Treatment (2003), Vol. 9, 424-431:, "Part 2: intervention, advances in psychiatric treatment (2003)", Vol. 9, pp. 432-438.

Schneider, W. (1886), *Review of Stockman DA, the Triumph of Politics*, Washington Post, Book World, April 27, p. 8.

SPICE Consulting on behalf of the Commonwealth Department of Health and Family Services "The kit: a guide to the advocacy we choose to do, booklet", available at: https://auspwn.files.wordpress.com/2014/05/austgov2009aguidetotheadvocacywechoosetodothekit.pdf (accessed 10 March 2022).

Weeks, N. "Co-delivering public services with users and communities", available at: www.govint.org/co-deliver/ (accessed 8 April 2022).

Corresponding author

Douglas John Holmes can be contacted at: douglas.holmes@uon.edu.au