The ALIVE National Centre
for Mental Health
Research Translation

THE ALIVE NATIONAL **WRITER-IN-RESIDENCE** PROGRAM

About the writer

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Issue 1

Understanding the growth of the lived experience discipline though an adaptive leadership lens.

As a mental health nurse, a co-designer of public mental health services and a person who identifies as having lived experience of mental ill-health, I have eagerly anticipated the growth of the lived experience workforce in mental health services. However, whilst my role enables me to be a key actor in facilitating this growth, I am also a witness to the challenges that surround the implementation of this vision. Recently, I have spent time reflecting on this challenge using an adaptive leadership framework (Heifetz 1994). Whilst the outcome of this reflection is that I have greatly underestimated the type and extent of leadership work required, I believe that analysing the challenges through this lens provides strategies for moving this change forward toward implementation.

The context

For decades, the mental health system has been designed and implemented by politicians, public servants, and healthcare professionals - that is, people with medical, nursing, social work, occupational therapy or psychology qualifications and clinical

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experience. However, there is an increasingly urgent need to listen and learn from mental health consumers and their carers, integrating their experiences, skills, and expertise as the "*lived experience discipline*" (Bassett et al. 2010; Gilbert & Stickley 2012). There are many roles within this discipline, ranging from "peer workers" (working alongside people experiencing mental ill-health, sharing insights and stories on recovery and wellbeing) to "lived experience policy officers" (using experiences to inform policies at government, hospital, and community levels). Roles have been further cemented and elaborated on in Victoria with the recent Royal Commission into Victoria's Mental Health System (State of Victoria 2021) and the Productivity Commission Report (2020).

Adaptive leadership

Adaptive leadership, as described by Heifetz (1994), is the work of bridging the gap between the values people stand for and the reality they face, which may pose conflicts to existing value systems. Interaction of different value systems is important for society, as it enables people to see challenges from different vantage points and shifts away from risks such as ‘group think’. This type of leadership is required when problems extend beyond requiring only technical expertise, instead encompassing areas such as ‘reform’ or ‘cultural change’. It requires leaders to induce learning by asking hard questions, in suitable timeframes, whilst maintaining a safe, holding environments for learning to occur within. For success, there needs to be a level of tension and urgency that mobilises people, whilst not causing any feelings of being overwhelmed. Issues are framed so that people can explore opportunities, challenges and tensions, and people work together towards agreeable outcomes. As such, outcomes and actions are owned by all who participate in the process.

What does this mean for Victoria’s Mental Health System?

The need for, and value in growing the lived experience discipline has been recognised for years, with many inspirational leaders working in this space. However, whilst there is an authorising environment from the Victorian State Government and other States and Territories are making headway to facilitate substantial growth, from

my observations, there are difficulties in both recruiting and retaining people into this workforce, especially within the public mental health system. The reasons for this are multifaceted and include a narrow focus on achieving the technical requirements for change whilst simultaneously overlooking the cultural complexities. For example, mental health professionals have historically "othered" those with mental ill-health, working in a well-unwell dichotomy. Consumers and carers of services also report varying levels of helpful-unhelpful interactions, with many reporting instances of iatrogenic harm (Katterl & Maylea 2021). Trying to move forward with the technical aspects of implementation without addressing these factors will not result in any enduring success.

Highlighting and focusing attention on the adaptative work required is essential to facilitate the cultural change required. Some examples of the technical and adaptive work needed are:

Technical	**Adaptive**
Development of position descriptions, role summaries and task lists Training and education for lived experience staff Training and education for healthcare professionals on working with lived experience staff Assigning line-managers, supervisors, and other professional supports	Discussions with all staff on the boundaries of the lived experience workforce, bringing attention to where the roles have the most value, the safeguards that are in place for staff and consumers to maintain therapeutic relationships and any other ideas, opportunities, or concerns [induce learning by asking hard questions]. Codesigning with all relevant staff the best ways to integrate lived experience staff into existing systems with a view to what might need to change.

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I see many places pushing ahead, in good faith, to meet the technical components of the change required without adequately paying attention to the adaptive components. This could be due to a lack of awareness, or understanding of, the amount of leadership work required to implement this type of change well.

In this reflection, I have only been able to describe the 'tip of the iceberg', and it is written only from one perspective. However, it is informed by my discussions with colleagues, my experiences, and I hope it opens a space for further conversations to happen. To end, I would like to pose three questions:

1) ***How can we better enable this adaptive change to happen?***

There are many leaders in this space who have fought hard for these changes. Additionally, the Royal Commission and other National Strategies, Plans and Frameworks have reinvigorated this conversation, and adaptive conversations are happening across Victoria. However, for many health and lived experience professionals, the space for adaptive conversations is limited. How can we ensure more consistent attention to this across the entire workforce?

2) ***How can we value and promote the adaptive change required?***

There is a specific focus from industry experts, health unions, and the Government to meet technical tasks in a timely manner. How can we equally embrace key performance indicators that measure for adaptive change, for example, staff surveys, assessments of culture or retention of lived experience staff?

3) ***What can you do today to support the leadership of adaptive change in this area?***

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Issue 2

The opportunities that lie within the grey: building better conditions for co-design

As an active and passionate co-designer in the public mental health arena, I enjoy having conversations with diverse groups of people around how to build better conditions for co-design. A recurring theme over the last six-months has been how to build a tolerance for, and a readiness to sit within ***the grey.***

Kelly-Ann McKercher describes the grey as the discomfort of not knowing, recognising, and grappling with complexity (McKercher 2020). As humans, most of us cannot tolerate high levels of ambiguity and discomfort for long periods of time, and we drift back to our (perceived) safe places of certainty. But the grey areas of co-design are where the magic happens (Tindall et al. 2021).

In codesign practice, I often see this as the space that sits between the experiences of all involved, a space where all co-designers are repeatedly called into and a space where innovation can occur. This is where the hard, robust conversations happen,

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primarily about how and why the opinions and ideas of the co-designers are influenced by their experiences, perspectives, and knowledge.

When the grey is embraced, and the why and how behind opinions and ideas are shared, I have witnessed the creation of solutions that transcend one person. The process of having these conversations can often have more meaningful impact than the final design outcomes (Cataldo et al. 2021) but it requires high levels of vulnerability. When done well, these types of conversation can facilitate the cultural change that is nearly always required to sustain design and change. When done poorly, they can lead to distress and the potential for harm.

So, how do we best embrace the grey? From my experience, three key requirements for facilitating the grey are: trust, curiosity, and supportive structures.

Trust

Co-designers require the opportunity to build trust with each other before they embark on the conversations that require vulnerability. Brene Brown (2021), in her recent podcast and her Dare to Lead work states: “Trust is not built in big sweeping moments. It’s built in tiny moments every day”. This makes me reflect on the time that is needed to establish good conditions before any design activities occur. From my experience in the public sector, this is very difficult when timeframes are tight and the process of finding the best people for any project reduces opportunities for extensive team building. However, overlooking this formative stage poses the risk of real harm to co-designers, and is therefore essential. Some of the strategies I use to promote early trust within the co-design teams I participate in and lead include linking co-designers early, embarking on non-design related activities that allow the opportunities for connection and facilitating spaces where co-designers get to know each other beyond their work personas. We drink a lot of coffee, eat a lot of cake, and laugh a lot.

Curiosity

Being in the grey requires participants to enter with a high degree of curiosity and a desire to learn. Ideas and solutions emerge through dialogue, and there needs to be an appetite for more questions than answers. If co-designers enter with a sense of certainty or defensiveness, there is no space for creativity. In my experience, and informed by Kelly-Ann McKercher's work, the role of a 'provocateur' is very beneficial for facilitating this (McKercher 2020, Tindall et al. 2021). The provocateur enters codesign without specific content knowledge or experience, and this allows them to question assumptions and norms. Their core role is to be a questioner, and this opens a space for others to question each other and themselves. I have found that this role also shifts conversations away from dichotomies, allowing nuances to be noticed and discussed. However, if someone is unable to specifically undertake this role, any person within a co-design process can model these behaviours, and in doing so, facilitate a safe place for curiosity.

Supportive structures

Whilst the grey is ambiguous, it needs to exist within a framework of safety. Co-designers benefit from clearly understanding the value they bring to the design process, their role and purpose, and who they can escalate any concerns to (McKercher 2020). It is helpful to have dedicated, named people to escalate concerns to. These people generally sit outside of the immediate team but remain known and accessible to the co-designers. I have also found it useful to have regular spaces where the process of co-design itself can be reflected on, for example through communities of practice, coaching or supervision.

What other strategies do you have for building your (or your teams) tolerance for sitting in the grey?

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Issue 3

Equity and co-design: Reflections of a facilitator

In my role, I frequently facilitate co-design activities. Participants, depending on the design context, generally bring one or more of the following perspectives:

- Lived experience, consumer
- Lived experience, carer
- Mental health clinical (e.g., doctors, nurses, social workers, psychologists)
- Lived experience professional (e.g., peer workers)
- Health service management
- Non-clinical staff (e.g., administration)
- Other relevant departments (e.g., capital works)

As a facilitator, I bring together all the key people who will be affected by the 'entity' being codesigned. My challenge is to enable a space for authenticity and vulnerability, that is also safe and productive for all participants.

I have found that many people mistake co-design in public mental health as solely hearing from those with lived experience of service use. Whilst I strongly agree with

the need for the voices of those with lived experience to be heard, elevated, and respected, I struggle when this becomes the only goal. In public mental health, understanding the perspectives and stories of others, such as clinicians and health service staff, is also paramount. Without this knowledge and expertise, design ideas and decisions may not be able to be feasibly implemented within the complexity of the mental health system.

The task of a co-design facilitator is therefore to build an environment of equity so that all perspectives can be heard and considered. I often come back to this image, which was produced by the Interaction Institute for Social Change (artist Angus Maguire).

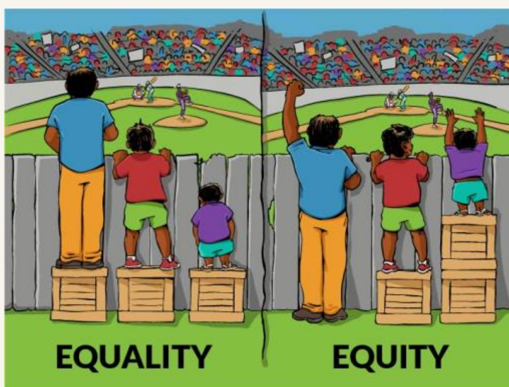

Image from interactioninstitute.org and madewithangus.com

Different people may need distinctive types of support to reach the same level of participation. However, are we considering this diversity in the support people need deeply enough before embarking on co-design activities? To highlight the extent and diversity of support required, I'll focus on some of the supports that two different participants groups (lived experience and clinical) may benefit from.

Lived Experience

In co-design, consumers and carers are invited into unfamiliar settings to discuss serious and often distressing topics on which they have personal experience (Cataldo

et al. 2021). For many, it is the first time they are sharing this type of information. It may be beneficial to provide and / or work through storytelling frameworks or readiness proformas with participants prior to co-design commencing. A range of resources are available here: https://aci.health.nsw.gov.au/projects/co-design/library-of-related-resources. During co-design, facilitators need to be emotionally attuned to participant's levels of comfort and discomfort, ensuring that people feel confident in their role and reasons (purpose) for being present. As there is a risk that power imbalances could be re-enacted during the co-design process (e.g., clinician–consumer), the facilitator needs to respond to any conscious or unconscious demonstrations of power that occur. Depending on the length and type of codesign activity, access to immediate support, debriefs, supervision, mentoring and reflection may also be required to maintain safety and enable full participation.

Clinical

Often overlooked are the supports that clinicians require to feel safe and supported during co-design. Clinicians are working with the impossible challenge of providing kind, person-centred care in a system that is standardised, risk-averse, under-resourced and highly regulated (Ballatt, Campling & Maloney 2020). There is a risk that when clinicians are placed into co-design activities, they may fall into the role of advocating for design decisions that may be restrictive or non-person centred. These outcomes are likely not what the clinician would want in an ideal (or any) situation. Or individual clinicians may take on the role of a scapegoat for an ineffective system, which can contribute to defensiveness, disengagement, or helplessness. Without suitable support and facilitation, this group may not be able to articulate the meaning, motivation and emotions behind an opinion or perspective. Clinicians often benefit from education on how to frame their experiences beyond a simple 'that's how it's done' to 'this is what I experience, and this is how it can impact the care I am providing'.

It is important to also be mindful that as humans, we do not fit well into tidy categories. We enter co-design as unique individuals, with a range of experiences that often blur the boundaries between defined roles (i.e., a consumer may also be a carer,

a clinician may also be a consumer). However, that is a discussion that requires its own reflection.

A useful resource that helps unpack the different needs of participant groups can be found here: https://aci.health.nsw.gov.au/__data/assets/pdf_file/0013/502240/Guide-Build-Codesign-Capability.pdf . This resource provides guidance for those entering co-design, focusing on capabilities, behaviours, actions, enablers, and barriers specific to each role. I have found it useful to guide conversations I have with participants prior to commencing co-design activities.

However, two actions that I hope you can take-away from this reflection are:

- To enter co-design with a willingness to get to know other participants as people. Most people are doing the best they can with the resources they have available to them.
- To make a commitment to maintain curiosity and listen to understand.

By doing this, we can contribute to safeguarding a space of equity for all present. Whilst some people may need more (or less) support to participate equally in the process of codesign, every person and perspective brings value. Understanding this opens a space for true innovation and cultural change to occur.

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Issue 4

A reflection on a recent publication by Isobel et al. (2021): ‘What would a trauma-informed mental health service look like?’ Perspectives of people who access services.

This fortnight, I read an excellent paper by Isobel, Wilson, Gill, and Howe (2021). They used an experience-based co-design method to build a greater understanding of what is needed to enact trauma-informed care in mental health services. Whilst there is a known need for services to be trauma-informed, the actual implementation of this is sporadic. This paper links the theory to clinical practice in an inspiring way.

I especially liked their methods, which demonstrated how co-design can be used in research to generate thoughtful outcomes, and form part of the solution.

What is trauma-informed care?

- Care that is *aware* of the high prevalence of trauma in those accessing mental health services, its effects, and that care provision itself can cause trauma.

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- It has underlying principles of safety, trustworthiness, choice, collaboration, and empowerment. It also focuses on positive relationships, staff behaviour and gender safety.

The problem

- There are large bodies of evidence demonstrating that trauma-informed care improves outcomes and experiences.
- There is also wide-spread policy support.
- However, whilst there is a commitment to implement trauma-informed care, it is mostly discussed conceptually, and its implementation remains sporadic.
- This paper aimed to explore the perspectives of consumers of mental health services in Australia and their family members, in relation to the question 'what would a trauma-informed mental health service look like?'

How was the research undertaken?

- The study was undertaken in New South Wales.
- It used experience-based co-design to understand the problem and generate solutions.
- Focus groups with consumers (n=10) and carers (n=10) drawn from multiple services across regional and metropolitan New South Wales were used for data collection, and thematic analysis was used to understand and analyse the data. The authors have published other papers that discuss additional results from the perspectives of staff and members of the Aboriginal community.
- Focus groups were co-facilitated in person by a clinician and consumer researcher.

The results: what can we do?

- Build awareness of trauma
  - Talk about and consider trauma
  - Provide access to trauma-specific information

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    - Move the focus from behaviours and medication to experiences, and how experiences can shape or influence lives

- Collaborate in care
    - Actively build trust through care planning and decision-making processes
    - Have choices on who provides care (e.g., gender) and how it is delivered (e.g., setting, medications)
    - Ensure orientation to settings and expectations

- Build trust
    - Communicate expectations
    - Be transparent around decision-making (the how and why decisions are made)
    - Ensure there are opportunities to reflect on the experiences of receiving care
    - Shift to more consumer-run and peer-led services

- Create safety
    - Through staff behaviours, for example, minimize overt displays of power.
    - Through the built environment, for example, through a welcoming entry point
    - Through policies, for example, ensure consistent access to therapeutic programs and activities

- Deliver a diversity of models
    - Reduce focus on diagnosis
    - Provide a diverse range of treatment options

- Consistency and continuity

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- Use primary clinicians well known to the consumer, and include well-established private and primary care treatment providers
- Ensure consistent, non-judgemental interactions from all staff
- Recognise the profound difference individual clinicians can have on a consumers recovery journey

My three key take-aways from the paper:

- Co-design can be part of the solution to embedding and enacting trauma-informed care
- Connecting as humans is at the heart of trauma-informed care
- Underpinning many of the specific recommendations are a need for better communication and ensuring that care is an active process that centres consumers and carers

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Issue 5

Defining and redefining expectations in co-design

Two fundamental factors for genuine co-design are clear and shared expectations of what is in scope for the initiative, and what is out of scope.

I work in a public mental health service, and I implement major reform initiatives. As such, the 'what' has often already been decided by Government policies. There commonly have been co-design activities at a high-level (e.g., at the Department of Health) on the key principles underpinning the initiative, and there may be an existing framework describing what the initiative should achieve and how.

My role as a program implementation manager is to ensure that the initiative is responsive to the needs, opportunities, and context of my local community. I use co-design to ensure that design and implementation are comprehensively informed by the people the initiative will most effect. As a public servant, I also aim to ensure that implementation of the initiative achieves the vision of the overarching policy and provides excellent public value (see figure 1).

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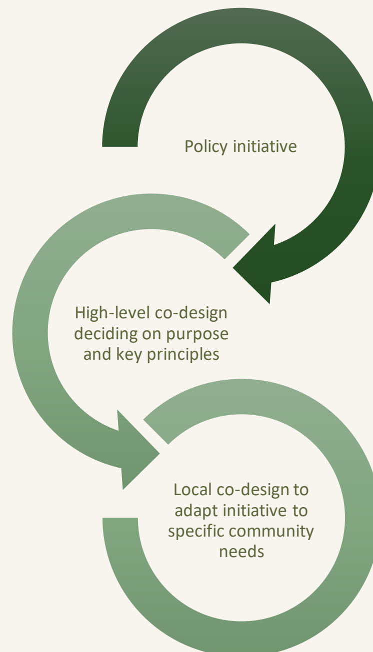
Figure 1 Codesign process



When establishing and orientating a local co-design team, I have found that it is essential to be clear about what is in scope for co-design. This involves a conversation on where we should target our energy, and how, as a collective, we can add most value to the initiative.

Scope is often informed by:

- The formal and informal authority we have as a collective
- Who we are reporting to, their priorities and their understanding of co-design
- Budgets
- Infrastructure opportunities and limitations
- Resource availability
- Interdependencies with other internal and / or external programs and initiatives

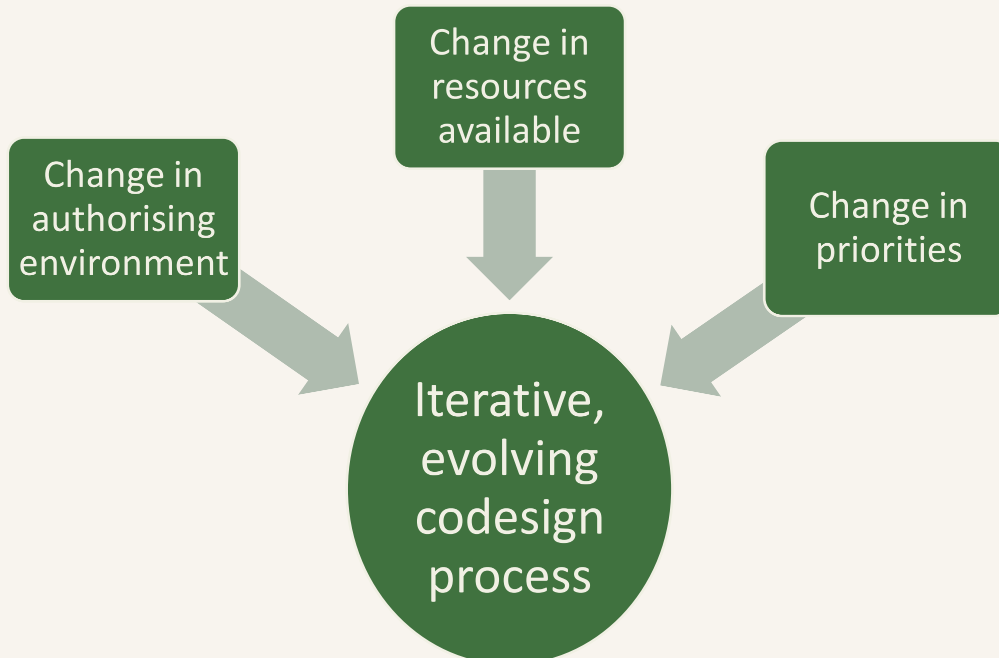
At times, as a group, we can get inspired (or distracted) and shift to designing aspects related to the initiative that are outside of our scope. If we don't realise this promptly,

it can result in frustration as we attempt to change things that we don't have the authority to influence. When we realise that this has happened, we often find it helpful to reflect on initial scoping discussions and remind ourselves of our purpose and scope.

Sometimes, scope can change during a project, and there is a need to regroup and restart the scoping dialogue. At times, this shift creeps in gradually and is not realised until the group reflect on why we are collectively experiencing frustration about the lack of change or delays in progress. At other times, the shift of scope marches in and can leave the team shocked and disheartened, especially if the reasons for change are not articulated or understood.

Most literature on co-design acknowledges that it is a cyclical, rather than a linear process, and that design will evolve as new knowledge and information is brought into discussions (e.g., NCOSS, 2017). However, in the literature, changes to the process are often framed to be a result of the iterative method of co-design. We have found that, just as commonly, changes can be due to the broader external context changing (see figure 2 for examples). Co-design usually takes time, and if co-designers are not attuned to the external context within which they are co-designing, many changes can occur around them within short timeframes. The significance of these changes on co-design may not be apparent until the process and / or initiative is affected.

Figure 2 Codesign and external changes



With this in mind, in my team we are starting to include scoping discussions as part of our regular co-design dialogue and reflections. This allows the opportunity for broader information to be shared, no matter how seemingly insignificant it appears at the time. We have found that it is also important to actively build and sustain relationships with key stakeholders and those people within the authorising environment. This ensures that there are spaces to reflect on any changes they are undergoing or that they foresee happening. For the local co-design team, building an understanding of the context within which co-design is happening, especially of the nuanced context of the public sector, helps us as co-designers maintain the agility and resilience needed for any co-design process.

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Issue 6

Balancing the perspective and the person in co-design

When recruited into co-design teams, we are generally assigned to the stakeholder group in which we can identify with the most. In mental health contexts, this is often consumer, carer, and clinician.

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However, the more co-design I engage in, the more I appreciate that most people do not fit into tidy groupings. Participants often have a primary perspective which draws them into co-design, but their contribution is influenced by many aspects of themselves. For some participants, there can be overlap across different stakeholder perspectives. For example, a consumer may have experience as a carer, a clinician may have experience as a consumer, or a carer may have experience as a clinician. This has led me to consider how to best recognise, acknowledge and manage this complexity.

I attempted to find literature and data on co-existing experiences, and what this means for co-design, but I could not easily find any. Interestingly, the evidence-base for mental health professionals with lived experience is starting to appear, with leaders such as King et al. (2020) unpacking the reasons why people choose to share (or not share) their lived experience in their professional lives. However, research such as this is highlighting the complexity of the situation, and we are likely a long way from fully realising the true extent of experiential overlap.

The Agency for Clinical Innovation (ACI 2019), in their guidance documents for different participant groups in co-design, make a distinction between those who have lived experience and those who are in professional roles. Of note, those in designated professional lived experience roles (e.g., peer roles) are given the same advice as other professionals, which is to share "your *professional* lived experience on the issue, and knowledge of how the service operates" (p. 19). The question of whether peer workers can speak about their own lived experience as part of a co-design team, or whether they should focus on their experience of providing peer support and working within the system, remains unclear.

Of note, there are researchers starting to explore the roles of peer workers in co-design and co-production. Aakerblom and Ness (2021) are currently undertaking a scoping review on this topic, with their scoping review protocol outlined in a recent paper. Their initial thoughts are that peer support workers involvement in co-design

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processes will be service specific, and they confirm the significant lack of research on this topic to date.

This leads me back to the whether we should ask people to come to co-design as their whole selves, or whether we should we ask people to represent only their assigned perspective. Unfortunately, I could not find any easy answers. I have summarised some of my personal thoughts in the below table, noting that there are benefits and risks to different approaches.

Scenario	Risks	Benefits
Person remains true to their perspective and only speaks to their assigned stakeholder grouping.	Person cannot truly be their authentic self within the co-design team, and key information may be lost.	Person can bring lived expertise (as opposed to lived experience, see Cataldo et al. 2021) to co-design, and there is clear attention to the perspective in question being represented equally.
Person shifts between their assigned stakeholder grouping and other experiences	The perspective in question may get lost in discussion, boundaries become blurred, and there may not be adequate attention to the levels of power and privilege	Person brings their true selves into the co-design process, enabling the group to connect as people rather than roles. The overlap between perspectives starts to be recognised.

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	brought into the co-design process.	

In practice, the best approach I have experienced is when a person mindfully steps out of their assigned stakeholder group, and they note that for a moment, they are speaking to another perspective. This may be because their experience is very different to what has been discussed to date, or because relevant information is at risk of being missed. This allows the content and experience to be present, whilst acknowledging the multifaceted aspects of the perspective being shared.

This area would benefit from some specific attention in the co-design literature and in lived experience research. It is important and can often cause confusion or ambiguity during co-design. It speaks to the complexity of human experiences, and this needs to be acknowledged and discussed as part of ensuring high-quality, person-centred co-design processes.

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Issue 7

Podcast Review: Emma Blomkamp and 'The Evolution of Co-Design'

Released on the 'This is HCD' podcast, May 5th, 2022,
https://www.thisishcd.com/episode/emma-blomkamp-the-evolution-of-co-design

One of my favourite podcast series is 'This is Human Centred Design (HCD)', which aims to educate and empower listeners about HCD (https://www.thisishcd.com). Episodes provide overviews and discussions on key design ideas, and the host interviews many leaders working in the design arena. I was drawn to this podcast because of the opportunity to learn more about the evolution of co-design. I also know of Emma Blomkamp as a renowned leader in co-design, and I was therefore excited to have the opportunity to finally sit down and listen to an interview with her on the podcast, released in May 2022.

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This podcast episode started with an overview of Emma's background, her PhD, and her journey into co-design. It then moved into examples of where she has undertaken co-design, and lessons learnt during the process. These lessons were opportunities for me to stop and reflect on my current practice, and consider how I could incorporate learnings into my approach.

Four examples of these learnings and questions, with the times (xx:xx) where they were discussed in the episode, included:

1) ***Check the assumptions that I may be bringing into any new design initiative*** (11:40)
   Emma provided an example of a co-designed behavioural change program, which worked towards reducing the rate of young, unlicensed drivers in a community. She described the need to check assumptions prior to embarking on fixing any problems or designing solutions. In this specific example, understanding assumptions led to a complete reframing of the initial problem, and resulted in the co-design of solutions that would not have been thought useful initially.

2) ***Reflect on what may be needed at different stages of co-design*** (14:28)
   In the above practical example, Emma described how initial research and design phases benefited from the participation of three key groups of people: (1) community members (2) professionals and (3) creative provocateurs. As the project progressed into delivery, the approach shifted towards having a group of community leaders who were present throughout implementation, which facilitated a space to iteratively test ideas. This discussion highlighted the advantages of reflecting on the different stages within co-design, and the potential benefits that may come from using different approaches and/or having different people being involved during the different stages of the process.

3) ***Be clear when describing what I mean by co-design*** (16:40)
   There was an interesting discussion on the evolution of co-design, and the idea that it has hit a sense of momentum within the service design community. Emma and Gerry Scullion (the host) discussed two risks with this. The first was that co-design could be seen as a re-packaging of design thinking, without designers understanding the unique aspects of co-design. The second risk was that due to an absence of agreed co-design industry standards, discussions or consultations may be called co-design. They agreed that the characteristic that makes it different from other design practices is the sharing of power. The characteristic that makes it different from community consultation is the focus on design.

4) ***Identify what is needed to further enhance co-design*** (28:40)
   Emma and Gerry discussed the future of co-design, and how it can be a beneficial approach to working with a range of complex societal problems and social systems (e.g., climate crisis, racial injustice, mental health). Its popularity means that there is a growing demand for capacity and capability building within different sectors. Emma described how people are currently wanting to build their skills and knowledge in this area instead of bringing in consultants to design for them, and that co-design coaching is therefore becoming increasingly needed. Emma finished by describing the support she is currently offering in this space, which includes a **co-design community of practice**. More information is available at her website - https://www.emmablomkamp.com/

I have found Emma's leadership in the co-design space both helpful and inspiring. The four specific lessons I have taken from this podcast have given me the opportunity to more deeply reflect on my co-design practice. The podcast was easy to listen to and I strongly recommend a listen.

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Issue 8

Co-design in a public mental health setting

This is my last piece as a writer-in-residence for The ALIVE National Centre, and I thought that I would end by providing an overview of how we are using co-design to design and implement several major projects at Barwon Health in Geelong, Victoria.

At Barwon Health, in our Mental Health Drugs and Alcohol Service, we started to refine our co-design processes a little over two-years ago. This was on the background of many years of working with, and engaging the community, consumers, carers, and staff in service design and delivery initiatives. We have been fortunate to have had many skilled advocates and practitioners supporting and undertaking co-design and participatory practices within our service for many years. However, the Royal Commission into Victoria's Mental Health System, in both its interim and full recommendations, provided clear strategic guidance that co-design should be at the heart of all new initiatives (State of Victoria 2021, https://finalreport.rcvmhs.vic.gov.au/recommendations/). This allowed us the opportunity to review and enhance our co-design resources and processes.

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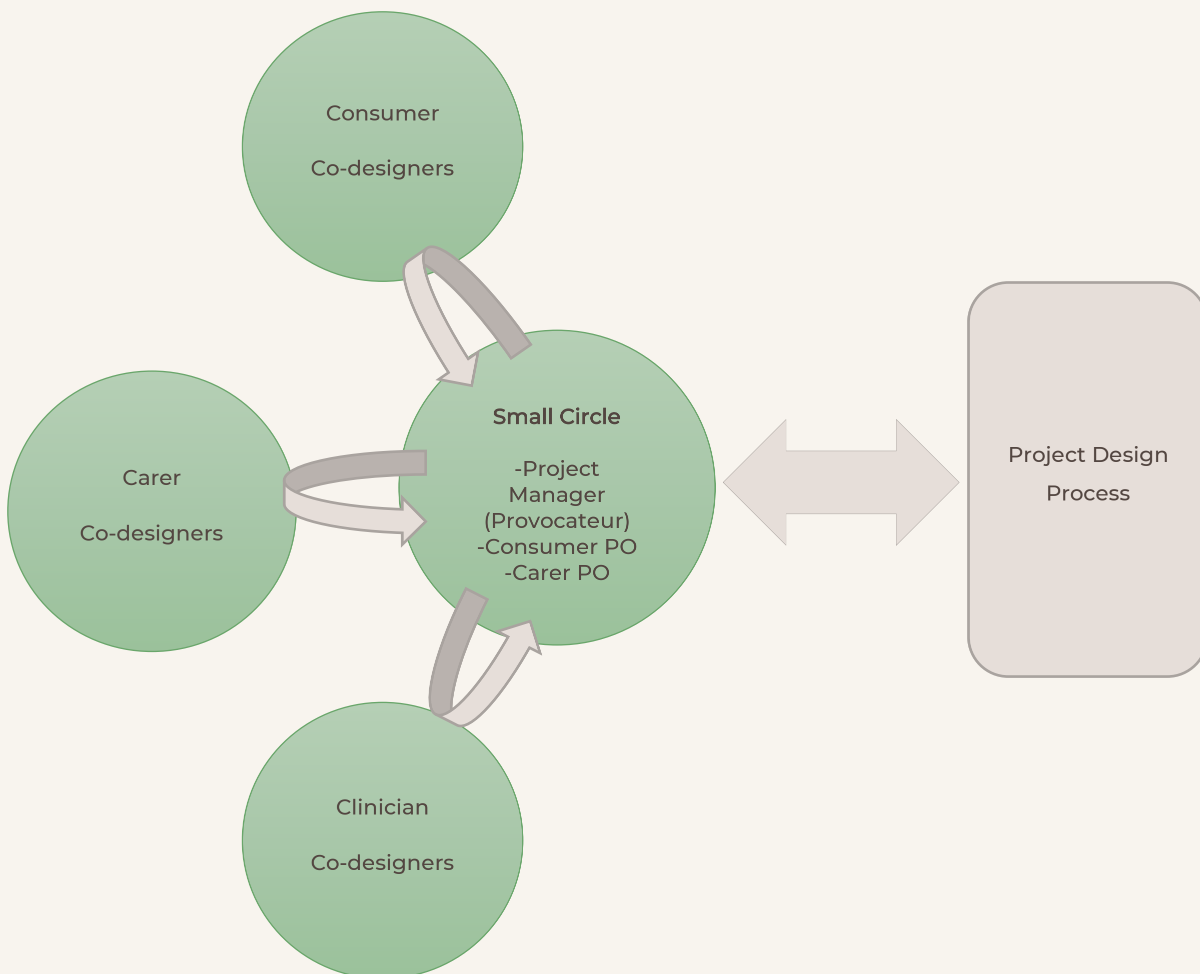
For every new initiative that we received funding to implement (e.g., a new acute mental health unit, hospital in the home, youth-PARC), we ensured that dedicated project officers with lived or living consumer or carer experience were employed. We initially started off small, with two project officers each working three days a fortnight. We have grown this team over time and currently have five project officers each working between four to six days a fortnight. For every initiative, a designated project manager and specific clinician time was allocated. Where possible, a person with no clinical or lived experience joined as a provocateur or a curious questioner, often in the project manager role. These positions formed the basis of small circle co-design teams (McKercher 2020).

We wanted to ensure that we engaged and captured broader perspectives than any one individual could bring to the co-design space. Using our Lived Experience Network, which is a carefully maintained record of previous and current consumers or carers of our service who are interested in service improvement, we created perspective-specific groups of co-designers. All participants were reimbursed for their time. We engaged these groups in ongoing design conversations, which facilitated these broader perspectives to inform small-circle decision-making process.

In a similar way, we also engaged groups of clinicians. Clinicians either engaged in co-design within their existing roles or we ensured that their clinical roles were backfilled. The approach to clinician engagement generally required more flexibility (e.g., the same people were sometimes not engaged throughout the process) to

incorporate practical challenges such as 24-7 rosters and COVID-related staffing shortages.

Conversations were led by the person within the small circle who best identified with the group (i.e., a project officer with consumer experience led the engagement with the broader consumer group). Careful records were maintained to capture all design conversations, as valuable information was captured that can be used to influence future similar projects where appropriate. This was also important to ensure that, as a service, we did not repeatedly ask the same people the same questions, without recognising previous substantive contributions.



For one of these projects, the co-design small circle team wrote a reflective paper on the opportunities and challenges of doing codesign in this way (Tindall et al. 2021).

We found that factors that enhanced co-design were:

- Formal, remunerated lived experience roles
- The allocation of time to establish and maintain an intimate and trusting team culture
- The capacity and safety for all team members to be vulnerable

Challenges included:

- Managing power differences
- Balancing the push to make fast-paced decisions
- Managing cynicism from experiences of previous projects

Since writing this paper, our learnings around co-design continue to evolve with each new project, and with the knowledge, experience, and passion that each co-designer brings to the space. We have been able to participate in, witness and learn from many conversations that have the potential to greatly change the culture of the mental health system.

We have also seen the enormous value that comes from employing and working alongside people with lived experience on a day-to-day basis. Whilst this has been common for peer roles, many service-design structures have been established with the assumption that people with lived experience will be invited in for specific meetings. Substantive cultural change does not happen within these set meetings. It happens in the informal office discussions and ad hoc decision-making emails that often occur throughout a working week. For me, personally, I can also say with certainty that each day I learn more about mental health and the mental health system from my colleagues with lived experience than I ever have before.

Facilitating spaces where diverse groups of people can hear different perspectives, understand the meaning behind opinions and decisions, and create new ways of

doing, has been the highlight of my career. I encourage anyone curious about co-design to participate in one of the many opportunities currently available. Co-design is hard but meaningful work that offers the opportunity to enrich the mental health system, forge new relationships and contribute to the mental health and wellbeing of our communities.

Keep up to date on current opportunities for learning and contributing to co-design activities on The ALIVE National Centre for Mental Health Research Translation's noticeboard on the digital platform www.alivenetwork.com.au

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