

CO-DESIGN IN MENTAL HEALTH SERVICES PLANNING: THE PERSPECTIVES OF THE STAKEHOLDERS IN MALTA

by

Janet Silvio

A dissertation presented to the Faculty of Health Sciences in part-fulfilment of the requirements for the degree in Master of Science in Mental Health Studies at the
University of Malta

May 2025



L-Università
ta' Malta

University of Malta Library – Electronic Thesis & Dissertations (ETD) Repository

The copyright of this thesis/dissertation belongs to the author. The author's rights in respect of this work are as defined by the Copyright Act (Chapter 415) of the Laws of Malta or as modified by any successive legislation.

Users may access this full-text thesis/dissertation and can make use of the information contained in accordance with the Copyright Act provided that the author must be properly acknowledged. Further distribution or reproduction in any format is prohibited without the prior permission of the copyright holder.



**L-Università
ta' Malta**

FACULTY/INSTITUTE/CENTRE/SCHOOL Health Sciences

DECLARATIONS BY POSTGRADUATE STUDENTS

(a) Authenticity of Dissertation

I hereby declare that I am the legitimate author of this Dissertation and that it is my original work.

No portion of this work has been submitted in support of an application for another degree or qualification of this or any other university or institution of higher education.

I hold the University of Malta harmless against any third party claims with regard to copyright violation, breach of confidentiality, defamation and any other third party right infringement.

(b) Research Code of Practice and Ethics Review Procedures

I declare that I have abided by the University's Research Ethics Review Procedures. Research Ethics & Data Protection form code FHS-2024-00197.

As a Master's student, as per Regulation 77 of the General Regulations for University Postgraduate Awards 2021, I accept that should my dissertation be awarded a Grade A, it will be made publicly available on the University of Malta Institutional Repository.

ABSTRACT

Background: Despite increasing international endorsement of co-design as a participatory approach in mental health services development, its practical adoption remains inconsistent, particularly in systems historically dominated by hierarchical and medicalised models of care. In Malta, co-design has yet to be systematically implemented, and the emotional, cultural, and structural readiness for such reform is largely unexplored.

Objective: This study aimed to explore how co-design could be implemented in the Maltese mental health system by examining the perspectives of key stakeholders, namely service users, healthcare professionals and managers, on the implementation feasibility, perceived benefits and possible barriers.

Design: A qualitative, exploratory, single embedded case study design, incorporating within-case analysis, underpinned by an interpretivist paradigm and informed by the frameworks of Arnstein's Ladder of Participation, the Four Key Elements of Co-Design, Critical Theory and Systems Theory.

Setting: Four mental health-service organisations were chosen to carry out this study, which included state-run, private and non-governmental services.

Participants: A purposive sample made up of 23 participants was recruited from the different services: 11 service users, 4 managers and 8 healthcare professionals with diverse roles within the mental health sector.

Methodology: Semi-structured interviews were conducted and analysed using thematic analysis. Data were coded using structural coding techniques in ATLAS.ti, with emerging

themes examined in relation to the study's theoretical frameworks. A reflexive, iterative approach was employed throughout the study to ensure transparency, credibility, and emotional sensitivity.

Results: Five themes emerged from the findings: (1) Valuing Lived Experience: A Foundation with Fractures, (2) Trust and Psychological Safety: The Emotional Prerequisites, (3) Structural and Logistical Barriers: The Weight of the System, (4) Relational Barriers: Communication Breakdowns and Conflicting Visions, and (5) Motivational Drivers and Perceived Impact of Co-Design. Whilst participants generally expressed support for co-design in principle, embedded mistrust, emotional fatigue, systemic resistance and pragmatic challenges were identified as potential hindrances to meaningful implementation. Service users often prioritised basic needs and emotional safety over participatory involvement, and concerns about tokenism, underrepresentation, and institutional inertia were recurrent.

Conclusion: Even if it is theoretically embraced by stakeholders, the study identifies that co-design requires significant systemic transformation for it to move beyond tokenistic engagement and be meaningfully implemented in Malta. The process needs fundamental structural changes, leadership buy-in, emotional readiness and trauma-informed practice. These findings provide a foundational understanding for developing contextually appropriate participatory mental health strategies in Malta.

Keywords: co-design; mental health services; stakeholders' perspectives; service users' involvement; participatory approaches.

DEDICATION

This thesis is dedicated to my husband Yakof. Thank you for your unwavering support, patience, and belief in me, especially during the most challenging periods of this journey. Your presence has been my anchor.

This work is also for all those who continue to believe in change, inclusivity, and justice within mental health systems.

ACKNOWLEDGMENTS

I would like to express my deepest gratitude to all those who supported me throughout the course of this research.

First and foremost, I extend sincere thanks to my supervisor, Dr. Paulann Grech, for her expert guidance, encouragement, and critical insight, which greatly enriched this study. Your mentorship was invaluable from inception to completion.

I am equally grateful to my Group CEO, Mr. James Sciriha, whose understanding and support were invaluable in easing the challenges of marrying the completion of the study with our busy working schedules.

Sincere appreciation to my colleague Mr. Matthew Vassallo, who offered constant motivation, thoughtful discussions, and practical advice along the way.

A heartfelt thank you goes to all the participants who generously shared their time, experiences, and perspectives. This study would not have been possible without your openness and courage. I also wish to acknowledge the vital role of the intermediaries who helped facilitate access and supported the coordination of interviews with care and professionalism.

Finally, I am deeply grateful to my parents for their lifelong encouragement and unconditional support. Your values and love have been the foundation of everything I strive for.

CONTENTS

ABSTRACT	iii
DEDICATION.....	v
ACKNOWLEDGMENTS	vi
CHAPTER 1: INTRODUCTION.....	1
1.1 Background of the Study	1
1.2 The Local Scenario	2
1.3 The Present Study.....	4
1.4 The Significance of the Study	5
1.5 Dissertation Structure.....	6
CHAPTER 2: LITERATURE REVIEW	7
2.1 Introduction	7
2.2 Inclusion and Exclusion Criteria	8
2.3 The Search Strategy	9
2.4 Identification and screening of studies	10
2.5 Literature Review	13
2.5.1 Introduction	13
2.5.2 Theoretical Foundations and Evolution of Co-Design in Mental Health Services ..	14
2.5.3 Benefits.....	18
2.5.4 Challenges	23
2.5.5 The importance of stakeholders’ perspectives	29
2.6 Conclusion.....	40
CHAPTER 3: METHODOLOGY	42
3.1 Introduction	42
3.2 Operational Definitions.....	42
3.3 Aim of the Study and Research Questions	43
3.4 Research Paradigm and Philosophical Underpinning.....	44
3.4.1 Interpretivism and Social Constructivism	44
3.4.2 Case Study Design.....	46
3.4.3 Theoretical Framework: Co-Design.....	47
3.5 Data Collection Methods	49
3.5.1 Qualitative Methods: Semi-Structure Interviews	49
3.5.2 Sampling Strategy.....	51
3.6 Data Analysis Approach.....	53

3.6.1	Conclusion	56
3.7	Ethical Considerations.....	57
3.7.1	Recruitment	57
3.7.2	Informed Consent.....	58
3.7.3	Confidentiality & Anonymity	58
3.7.4	Minimizing harm	59
3.7.5	Reflexivity.....	59
3.8	Quality and Trustworthiness.....	60
3.8.1	Credibility.....	60
3.8.2	Dependability	61
3.8.3	Authenticity	61
3.8.4	Commitment and Rigor	62
3.8.5	Transparency.....	62
3.8.6	Impact and Quality	62
3.9	Conclusion.....	63
CHAPTER 4: DATA ANALYSIS		64
4.1	Introduction	64
4.2	Data Set	64
4.3	Data Findings	65
4.4	Theme 1. Valuing Lived Experiences: A Foundation with Fractures	68
4.4.1	Valuing Lived Experiences and Knowledge	68
4.4.2	Inclusive and Meaningful Engagement	76
4.5	Theme 2. Trust and Psychological Safety: The Emotional Prerequisites	80
4.5.1	Emotional and Psychological Impact	80
4.5.2	Trust, Safety and Relationship Building	83
4.6	Theme 3. Structural and Logistical Barriers: The Weight of the System	87
4.6.2	Barriers to Service Users' Participation	98
4.7	Theme 4. Relational Barriers: Communication Breakdowns and Conflicting Visions 102	
4.7.1	Barriers to Dialogue and Shared Vision	103
4.7.2	Professional Relational Barriers.....	106
4.8	Theme 5. Motivational Drivers & Perceived Impact of Co-Design.....	111
4.8.1	Motivation and Willingness to Engage	111
4.8.2	Benefits of Co-Design	113
4.9	Conclusion.....	119

CHAPTER 5: DISCUSSION	120
5.1 Introduction	120
5.2 Thematic Discussion	122
Theme 1: Valuing Lived Experience: A Foundation with Fractures	122
Theme 2: Trust and Psychological Safety: The Emotional Prerequisites	126
Theme 3: Structural and Logistical Barriers: The Weight of the System	130
Theme 4. Relational Barriers: Communication Breakdowns and Conflicting Visions	139
Theme 5: Motivational Drivers and Perceived Impact of Co-Design	144
5.3 Conclusion.....	148
5.4 Revisiting the Research Questions	149
Research Question 1:.....	149
Research Question 2:.....	151
Research Question 3:.....	155
CHAPTER 6: CONCLUSION	159
6.1 Summary of the research study.....	159
6.2 Practical Implications	160
6.3 Strengths and limitations of the study.....	161
6.3.1 Strengths.....	161
6.3.2 Limitations	161
6.4 Recommendations for Future Research.....	162
6.5 Conclusion.....	163
References	165
APPENDIX A: ETHICS APPROVAL	180

LIST OF TABLES AND FIGURES

Table 2.1 - Inclusion and Exclusion Criteria for Literature Review	8
Table 2.2 - The search terms used in the search strategy	10
Table 3. 1 - Participants recruited	52
Table 3. 2 - Inclusion and Exclusion Criteria of Participants.....	52
Table 4. 1 - Thematic coding structure	67
Figure 2. 1 - Flow diagram describing the screening process based on Moher et al., (2009)	12

CHAPTER 1: INTRODUCTION

1.1 Background of the Study

In recent years, co-design has become a prominent framework for the re-organisation of mental health services, moving away from traditional top-down implementation models of service delivery to frameworks that position service users as architects in the design of services (Donetto et al., 2015; Palumbo, 2016). Rooted in participatory values, co-design aspires to democratise healthcare by recognising the lived experiences of service users as legitimate and essential sources of knowledge (Robert, 2013; Slay & Stephens, 2013). This participatory ethos is particularly critical in mental health, where service structures have historically marginalised users and prioritised clinical expertise over personal experience. While co-design is widely promoted in policy and academic discourse, its practical implementation within mental health is inconsistent, being more aspirational rather than actualised in many systems. Challenges of the process have been pointed out in various studies, highlighting tensions related to power dynamics, tokenistic participation, and systemic resistance to cultural change (Pinfold et al., 2015; Rose & Kalathil, 2019).

This study chose to focus on co-design rather than co-production, since the latter is a broader approach that includes all stages of service development, whereas co-design is more focused on the collaborative design phase. Even though both approaches value stakeholder involvement, they differ in their scope and emphasis with co-production encompassing the entire process, from initial conception to implementation and evaluation and co-design being primarily concerned with the design and development stages, not necessarily the implementation and evaluation.

Existing studies focus on documenting user experiences after participation in co-design initiatives, typically analysing retrospective accounts. Very few studies examine perceptions prior to implementation, including how stakeholders envision co-design, what emotional and structural readiness exist, and what risks or resistance may already be present (McGowan et al., 2024; Visser et al., 2024).

This gap is particularly relevant in contexts like Malta, where participatory mental health reform is still nascent. The lack of formalised co-design practices within Maltese mental health services provides an opportunity to explore stakeholder attitudes at an anticipatory stage, contributing to a more holistic understanding of what is required for genuine inclusion and transformation.

1.2 The Local Scenario

Mental health services in Malta have traditionally been dominated by the medical model, with a limited history of participatory approaches. National policies have increasingly called for person-centred, inclusive service models, but practical foundations to realise these aspirations have been weak or absent. Co-design as a formalised approach has never been systematically introduced in Maltese mental health services. Consequently, there is a significant knowledge gap regarding how key stakeholders, particularly service users, professionals, and managers, perceive co-design, and what cultural or institutional factors might hinder or facilitate its future implementation.

The National Mental Health Strategy identifies important goals, like adopting systems-based approaches, providing outcome-driven mental health care, and promoting inter-sectoral approaches to care provision. The strategy also recognises the need to strengthen community-based services, and to re-orient care away from hospital-dominated systems. However, despite these progressive objectives, the strategy does not identify co-design, or participation of peers or experts by experience in planning or service design, as a priority. Although it acknowledges the importance of families and responsible carers in identifying gaps and shaping services, nowhere does it recognise or institutionalise the role of service users themselves in shaping mental health services (Office of the Deputy Prime Minister, 2018).

Despite widespread global consensus that using the expertise of service users at individual, service and national level can produce more responsive, effective and empowering care systems, this expertise remains underutilised. The absence of a suitable governance framework that integrates the distinct services and professions involved in mental healthcare further perpetuates a fragmented and inefficient system. Communication breakdowns between levels of care, especially between community, secondary and tertiary services, hinder continuity and coordination. The system remains largely medically led with inadequate resource provision of rehabilitation, reintegration and long-term recovery planning.

Given the small size of Malta and its centralised service provision, institutional cultures are generally hierarchical and resistant to rapid change. Thus, understanding stakeholder perspectives at the pre-implementation stage may present the opportunity to generate strategies for participatory reform that are grounded and sustainable.

1.3 The Present Study

This study explores the perspectives of service users, healthcare professionals, and managers on co-design within Maltese mental health services, to investigate perceived enablers and barriers, as well as the emotional responses perceived to be associated with participatory service development. It draws on rich narrative accounts to explore the relational, emotional, and systemic dynamics that shape stakeholder attitudes toward co-design through a qualitative single embedded case study design guided by an interpretivist paradigm.

Data collection consisted of semi-structured interviews conducted with participants from different mental health service sites. Thematic analysis was used to code and interpret the data, and findings were discussed in relation to the theoretical frameworks and existing literature. This triangulation allowed for a deeper critical examination of structural patterns and discursive tensions that may influence future co-design initiatives.

The research questions leading this study are:

1. What is the perspective of service users and healthcare professionals in relation to their inclusion and contribution to designing mental health services?
2. How does management view the inclusion of service users in the design of mental health services?
3. What do service users and other stakeholders perceive as being the potential hindrances to an implementation of a co-design approach and do they believe it would be beneficial?

1.4 The Significance of the Study

This research offers a contextually novel contribution to the co-design literature by exploring perceptions of co-design in a system where the approach has not yet been formalised, addressing a critical gap in literature which is often overlooked (McGowan et al., 2024; Visser et al., 2024). It is one of the few studies that explores pre-implementation attitudes in a mental health context, providing insight into anticipatory barriers and emotional responses that may otherwise go unnoticed in post-implementation evaluations. It is also novel in its inclusion of diverse stakeholder voices, and in its comparative lens that allows for the exploration of convergences and tensions between groups. Finally, this study is the first positioning findings on co-design within a national context, where participatory governance in mental health remains conceptually present but practically absent.

Psychological costs of tokenism, self-doubts about credibility, and structural marginalisation of service user contributions, were amongst the emotional and epistemic dimensions of co-design that surfaced from this study, phenomena usually documented in post-implementation settings (Moll et al., 2020; Scanlan et al., 2020).

Importantly, the study challenges the notion that co-design is a universally desirable solution. Several service users in this study emphasised that before contributing to system change, their basic needs and psychological safety must be met, an insight that urges a rethinking of participation through a trauma-informed, context-sensitive lens (Heerings et al., 2022; Tindall et al., 2021).

1.5 Dissertation Structure

The dissertation is structured as follows:

Chapter 1 presents the background of the study, the local context within which the study is undertaken, and the significance of the study. Chapter 2 presents a critical discussion of international literature, identifying gaps and informing the conceptual foundation of the study. Chapter 3 outlines the philosophical underpinnings, research design, as well as the methods of data collection and analysis used. Chapter 4 presents the empirical data collected. In Chapter 5, the key themes and their implications are highlighted by interpreting the findings through theoretical frameworks and literature. In Chapter 6, the study is summarized, practical implications are identified, followed by the overall strengths and limitations, and suggestions for future research.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter delineates the theoretical frameworks and search strategy employed to identify research focused on co-design in mental health services planning. It also offers a critical evaluation of the existing literature and underlines the identified gaps.

Despite the identified benefits of co-design in enhancing service user engagement and improving care outcomes, there remains insufficient understanding regarding the perceptions of healthcare professionals of co-design prior to their participation in such processes. Effective implementation of the process within mental health services planning may be hindered by prior beliefs and assumptions related to tokenism, power dynamics, professional expectations and sustainability (Hall et al., 2023; Vella-Brodrick et al., 2023; Vennik et al., 2016).

The extraction of relevant literature was systematically guided by the predetermined inclusion and exclusion criteria, the detailed delineation of which will be elaborated upon in the subsequent section. Through this review process, it becomes evident that more attention is warranted regarding the perspectives of stakeholders on the co-design approach prior to its implementation. This study aims to fill this gap and contribute to the broader understanding of the effectiveness of co-design in mental health services planning.

2.2 Inclusion and Exclusion Criteria

The research questions addressed in this review are:

1. What is the perspective of service users and healthcare professionals in relation to their inclusion and contribution to designing mental health services?
2. How does management view the inclusion of service users in the design of mental health services?
3. What do service users and other stakeholders perceive as being the potential hindrances to an implementation of a co-design approach and do they believe it would be beneficial?

The Population, Exposure and Outcome (PEO) method by Khan et al. (2003), was used to develop the criteria that determined the studies that were extracted for this review. Table 2.1 describes the inclusion and exclusion criteria

Table 2.1 - Inclusion and Exclusion Criteria for Literature Review

PEO	Inclusion Criteria	Exclusion Criteria
Population	Adults over 18 years of age. Service users, managers, healthcare professionals.	Participants less than 18 years of age since the focus of the researcher was on adults.
Exposure	Participants who use mental health services. Professionals working in mental health services.	Studies not written in the English language. Non-peer reviewed source.
Outcome	Knowledge of co-design, including benefits and challenges. Perspectives on co-design approach in mental health services planning.	Experiences other than mental health services.

After establishing the inclusion and exclusion criteria, the researcher developed a search strategy using electronic databases. The next section provides a detailed description of the search strategy.

2.3 The Search Strategy

A comprehensive literature search was undertaken utilizing multiple electronic databases to enhance the retrieval of pertinent studies and mitigate potential search bias, as recommended by Booth, Sutton, and Papaioannou, 2016. The search was conducted within the University of Malta's electronic resources, accessing the following databases: Academic Search Complete (EBSCO), Medline (ProQuest), PsycINFO (EBSCO), and Wiley Online Library. The search parameters were strictly confined to publications in the English language, which may inadvertently introduce language bias by precluding the inclusion of non-English studies (Higgins et al., 2001).

To further enrich the findings, reference lists from the identified full-text articles were meticulously reviewed in pursuit of additional relevant literature. Primary sources were prioritized, as they offer the most direct evidence concerning the research query. In instances where access to the original articles was unattainable, secondary sources were considered a suitable alternative. The search timeframe spanned from 2005 to 2024, to ensure relevance and currency of the literature. The literature search was conducted between May 2024 and January 2025, employing a set of targeted search terms, the specifics of which are delineated in Table 2.2.

Table 2.2 - The search terms used in the search strategy

PEO	Population	Exposure	Outcome
Search terms	Stakeholders, caregivers, healthcare professionals, service users, health services managers	Co-design, co-design in mental health services planning, perspectives of stakeholders on co-design, value of stakeholders' perspectives in mental health services planning	Benefits and challenges of co-design in mental health services; perspectives of stakeholders' inclusion in co-design

Using the search terms: “co-design”, “mental health”, “perspectives” and “stakeholders” generated 1,072 results between the range dates provided. To focus on the specific research questions, the terms were combined using “of” and “and”. A description of the screening process carried out in identifying the relevant studies is outlined in the following section.

2.4 Identification and screening of studies

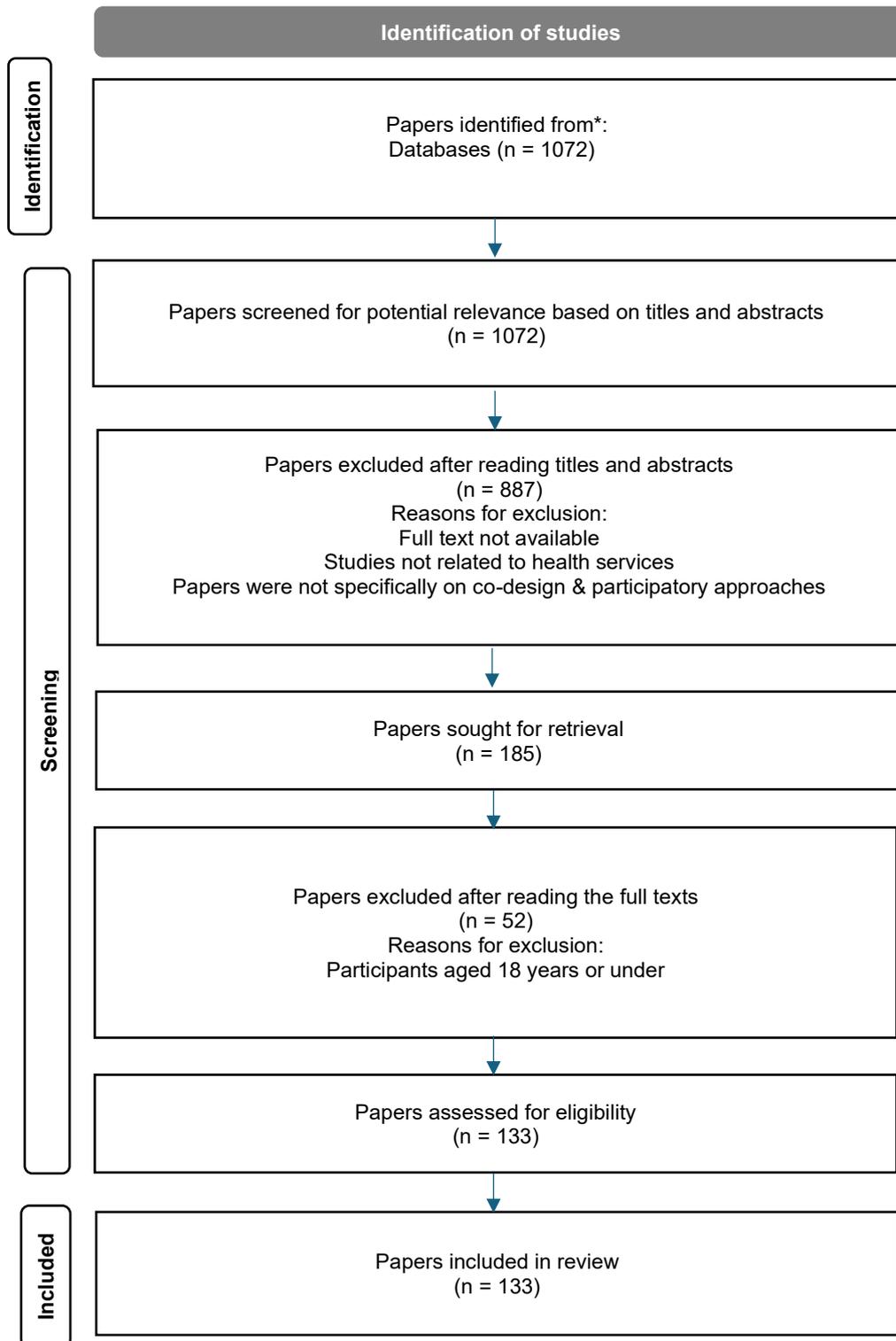
PRISMA guidelines (Moher et al., 2009) were followed to identify papers for eligibility to use in this review. Figure 2.1 presents the flow diagram describing the screening process based on Moher et al. (2009). A total of 1,072 articles were screened for eligibility, based on the titles. Papers whose eligibility could not be assessed based on titles, had their abstracts reviewed. After the exclusion of papers which were not directly relevant to the topic of interest, 185 papers had their full texts read. It wasn't possible to assess all papers' eligibility by only reading the titles and abstracts.

The PRISMA guidelines (Moher et al., 2009) were adhered to in identifying and screening papers for inclusion in this review. As illustrated in Figure 2.1, the screening process followed Moher et al.'s (2009) structured flow diagram. An initial pool of 1,072 articles was screened based on their titles. When eligibility could not be determined from the title alone, abstracts were reviewed. Following the exclusion of articles not directly related to the topic, 185 potentially relevant papers were shortlisted for full-text review. Full texts were examined in cases where eligibility could not be confirmed through titles and abstracts alone. Articles were excluded if they: (1) did not focus specifically on co-design or participatory approaches; (2) lacked accessible full texts; or (3) did not address mental health services.

At this stage a total of 133 studies were included in this review for critical appraisal. These studies were included to cover a comprehensive understanding of the background of co-design and its importance for mental health services planning, as well as for understanding the perspectives of stakeholders taking part in a co-design process.

This meticulous approach ensured the inclusion of high-quality studies pertinent to the research questions which was then followed by a re-read of the papers to conduct a critique of these studies. The following section presents a critique of the literature in relation to the importance of co-design in mental health services planning through the perspectives of different stakeholders

Figure 2. 1 - Flow diagram describing the screening process based on Moher et al., (2009)



2.5 Literature Review

2.5.1 Introduction

The involvement of service users in the conception and delivery of healthcare services has received increased awareness as being crucial for promoting effective and person-centred care. In the past, the focus was directed towards enhancing service efficacy and providing operational safety; however, this has changed, especially within mental health services, shifting towards a paradigm that is more recovery-oriented and values the experiences and perspectives of the recipients of care.

The dynamics of how mental health care is provided has also shifted from a top-down approach to one that encourages joint participation and the active involvement of users (Bate & Robert, 2007; Donetto et al., 2015). This socio-political shift affirms the consistency of participatory methodology among health services research and development (Arnstein, 1969; WHO, 2015). Mental health services and researchers are consistently looking for new ways to support participation and involvement of all relevant stakeholders (Palmer et al., 2019). Meaningful participation, as articulated by Palmer et al., 2019, is having individuals equally participating in the decision making affecting their care plan, service design and improvements, or evaluations that affect them.

A considerable amount of criticism has been attributed to the traditional model of mental health planning predominately dominated by professionals deciding for service users, due to its inadequate emphasis on user needs and its overall efficacy (WHO, 2009). These deficiencies brought about the recognition of the strengths associated with co-design, which

distinguishes itself for its participatory and collaborative approach that incorporates the perspectives and lived experiences of both users and professionals in the design and development of services. This methodological shift is emphasized by an increasing volume of literature supporting the significant involvement of service users in the design of their care experiences (Cree et al., 2015; Mockford et al., 2012; Wilkinson & McAndrew, 2008), thus promoting a more inclusive framework for mental health service provision. As a result, co-design has emerged as a significant paradigm in the sector, promising improved service quality and patient outcomes by incorporating various perspectives in the planning process.

This literature review explores the existing research on co-design in mental health service planning, revisiting its historical background and theoretical foundations, while highlighting its distinct benefits, deep-rooted challenges, and broader implications for the present and future.

2.5.2 Theoretical Foundations and Evolution of Co-Design in Mental Health Services

The concept of co-design is rooted within the culture of Participatory Design that originated from Scandinavia in the 1970s. This model calls for the active involvement of users as the participants in the design process so that their distinct experiences of stakeholders are identified and respected (Osborne, Rodonor, & Nasi, 2013; Sanders & Stappers, 2008). In recent years the participatory ideology supporting active involvement in healthcare decisions, has been cultivated in what is now referred to as 'Participatory Zeitgeist' which unifies lived experiences into research and design (Palmer et al., 2019; Schubotz, 2019).

The increased appreciation towards the value of lived experience in the development of delivery systems marks the paradigm shift in approach that co-design has undergone from designer-centric to user-centric (Schubotz, 2019; Steen, 2013). Such growth is delineated by realisation of the significant influence the unique insights of service users can bring to service design, thereby making their active participation through different stages of the design process fundamental (Mulvale et al., 2016; Oliver, Kothari & Mays, 2019).

The underpinnings of co-design are grounded into several interrelated theories and methodologies such as Sociotechnical Systems (STS) Theory, Constructive Learning Theory and User Centred Design (UCD) amongst others. These frameworks all jointly emphasize the need to understand social interactions and technical components in the design process.

The interaction of social and technological environments reveals a powerful component of Socio-Technical Systems (STS) theory, emphasizing careful attention to these interactions during decision making (Cherns, 1976). Moreover, Constructivist Learning Theory and Critical Theory place a lot of emphasis on the importance of an equal, inclusive and collaborative approach, inviting practitioners to genuinely engage with service users for designing interventions and services which represent a common and shared vision (Habermas, 1984; Piaget, 1973; Vygotsky, 1978). Merging the methodologies of User-Centred Design (UCD) and Design Thinking provides an enhanced understanding of lived experiences and places the individual at the centre during the design stage (Brown & Wyatt, 2010; Lyon & Koerner, 2016).

It is important to appreciate at the outset that there is some overlapping use of the concepts 'co-design' and 'co-production' in the literature. Both processes underscore collaboration, engagement with stakeholders, and mutual learning. Nonetheless, while the term co-design

primarily relates to the design of services, co-production extends to the co-creation of services, policies, and programs with service users and professional stakeholders working as partners. Co-design and co-production share foundational principles, but co-production places particular emphasis on the active participation and engagement of service users through both the design and delivery process, creating shared responsibility, ownership, and accountability among all stakeholders, whereas co-design is limited to the planning stage of the initiative. If co-production practices are embedded within co-design initiatives, the information gap between design expectations and the users' experience can be narrowed down and the likelihood of achieving better and sustainable outcomes is increased (Palmer et al., 2019; Robert et al., 2022). However, in a society in which neither of the two have yet been implemented, it might be considered wise to start with involvement in the planning aspect only to move to co-production once the co-design approach has been consolidated.

With the growing focus on co-design approaches in social innovation processes, these co-design methodologies require systematic inclusion at all tiers of mental health service delivery. This inclusion makes it possible for clinical professionals, service users, and caregivers to work holistically to solve multifaceted problems and make sure that services are designed and provided for the target population (Byrne & Wykes, 2020; Rosen et al., 2020).

Globally, numerous co-design methodologies have emerged to address complex healthcare challenges. Generally, processes like the UK Design Council's 'Double Diamond' illustrate how insights are synthesized into innovative solutions through iterative phases of divergent and convergent thinking (Blomkamp, 2018). By promoting a balanced power dynamic among stakeholders, co-design endeavours to foster collaboration between service users and

professionals, resulting in more effective and relevant service provision (Slay & Stephens, 2013).

An extension of the comprehensive co-design methodology, specifically targeted for the healthcare sector is Experience-Based Co-Design (EBCD). EBCD bases itself on the core principles of co-design like collaboration, continuous development and active user involvement whilst integrating the lived experiences from different stakeholders in the design process. Developed in the mid-2000s, EBCD underscores the value of understanding and appreciating lived experiences to design healthcare service which places the user at the centre (Bate & Robert, 2006; Robert, Cornwell, & Locock, 2015). Apart from ameliorating service quality and efficiency, EBCD, through its facilitating approach in producing effective partnerships between service users and staff, cultivates empathy, dialogue, and a sense of ownership among participants. It also strongly echoes the needs and wishes of those who will benefit from such services, manifesting the transformative power of co-design in delivering high quality, person-centred care (Bate & Robert, 2007).

While the significance of co-design in mental health is being increasingly accepted, its success in practice revolves around its ideological underpinnings. It is argued that to genuinely co-design, there is a need to interact as equal participants, which calls for a cultural paradigm shift that recognizes users as valuable contributors to the design process (Gordon & O'Brien 2018). Nonetheless, existing literature reveals structural challenges that inhibit co-design initiatives, especially the need for regular staff education and assistance to enable desired engagement (Gordon & O'Brien 2018; Moll et al. 2020).

In conclusion, it is crucial to understand that co-design has evolved to become one of the most critical stages of the research and development cycle of mental health services due to its implication of engaging all relevant stakeholders in the co-design process. The way mental health interventions are designed through co-design, guarantees maximum effectiveness as well as social equity since it places the actual target user of the service being developed at the epicentre of the co-design activities (Porche et al., 2022). Such a comprehensive and participatory strategy to co-design opens new avenues for improving and transforming the traditional healthcare models, bridging the gap between research and practice, and supporting a more participatory mental health outlook.

2.5.3 Benefits

Co-design fosters a participatory framework that values the lived experiences and expertise of all stakeholders through the facilitation of empowerment, collaboration, and reciprocity among participants. Such an integrative model promotes mutual learning, enabling individuals to transition from passive recipients to active collaborators and acknowledges the valuable knowledge and experience stakeholders bring, which not only empowers them, but enhances the relevance and responsiveness of developed solutions (McKercher, 2020; Pinfold et al., 2015; Staley, 2009).

The involvement of service users in healthcare settings has been associated with higher patient satisfaction and improved clinical outcomes (Griffin et al., 2004; Modigh et al., 2021; O'Mara et al., 2013; Palmer et al., 2019; Slattery, Saeri & Bragge, 2020). Improved social

networks, lower stigma and increase well-being were also identified as some of the social and structural outcomes of co-design (Slay & Stephens, 2013).

More recent systematic reviews have also evidenced the role of co-design in developing effective social prescription interventions demonstrating its importance in engaging community stakeholders to come up with solutions to health problems in the community at large (Thomas, Lynch, & Spencer, 2021). These results are in line with other studies showing that co-designing initiatives foster a sense of attention and recognition among service user, rather than seeing them with as a utilitarian perspective where they are merely users of the healthcare system (Batalden et al. 2016; Palumbo, 2016).

Co-design fosters initiatives targeting both structural and cultural aspects of service provision that considers the breadth of service improvement. This approach also enhances treatment access, which speaks to the essence of co-design as a means of ensuring responsive services aligning with service user needs (Illback et al., 2010; Lwembe et al., 2017; O’Keeffe et al., 2015; O’Reilly et al., 2022). As a result, there is greater likelihood of intervention feasibility, adoption, implementation, and sustainability, thus demonstrating the need for and the importance of engaging community stakeholders in health research initiatives (Bombard et al., 2018; Donetto et al., 2015; Ezaydi et al., 2023; Modigh et al., 2021; Sheikan et al., 2023).

Community members are empowered to actively participate in social change by amplifying their voices using co-design methodologies (Brett et al., 2014). Clinical guidelines, such as those from the National Institute for Health and Care Excellence, also points out that families are crucial in their involvement both within the institutional setting as well as in the community (National Institute for Health and Care Excellence [NICE], 2016). It is posited,

therefore, that a “triangle of care” that consists of service users, healthcare staff, and caregivers working together will improve recovery and safety (Worthington, Rooney, & Hannan, 2012).

Better mutual understanding and the development of community connections are further benefits derived through co-design, together with the advancement of collective responsibility among service users, service providers and healthcare professionals (Boaz et al., 2016).

Through the substantial priority placed by the co-design approach in implementing equality between different stakeholders, service users are positioned as essential contributors to the design, delivery and assessment of healthcare services (Dunston et al., 2009). The recognition of the experiential knowledge of service users as being equal to clinical evidence, challenges traditional patient-provider dynamics, thus promoting patient-centred care (Palumbo, 2016). This democratisation of knowledge during co-design contributes to breaking down established power hierarchies, placing part-ownership in the hands of service users (Beckett et al., 2018).

Co-design can rekindle the original commitment that health practitioners had towards core values and enhance the quality of their work life (Robert, 2013; Tollyfield, 2014). Increased engagement and satisfaction among service users can result in greater job satisfaction, less burden, and increased practice opportunities for professionals (Bate & Robert, 2006). This increased engagement has helped foster new, more positive interactions between staff and service users, helping in rebalancing traditional power dynamics in ways that benefit all stakeholders (Iedema, Merrick, & Piper, 2010; Robert, 2013). Clarke et al. (2017) highlights the extensive weight that service users and staff attribute to changes in personal attitudes,

behaviour, and the organizational culture of healthcare teams which jointly create positive aptitudes resulting in improved organization function.

In summary, true to its principles, a clear direction towards empowerment, inclusion, and recognition of the importance of lived experience can be witnessed from the development of co-design practices in the provision of mental health services. In recent studies, co-design has been described as an enabler for transformative relationships between stakeholders involved in the process as well as a sustainer for a deeper understanding of service effectiveness, which may result as critical for improving accessibility, resilience and health equity (McKercher, 2020; Palmer et al, 2019).

Co-design in healthcare improvement is broadly identified with its ability to improve operational efficiency and encourage autonomous participation. Advocates argue that this approach fosters equity, clarity, and accountability (Verschuere et al., 2018; Williams et al., 2020). Nevertheless, most published research reveals an excessive positive perspective, regularly omitting the potential deficiencies and shortcomings underlying co-design initiatives.

The body of literature cited presents a strong endorsement of co-design's potential; however, there are notable methodological limitations in how this evidence base was constructed.

Many authors (Griffin et al. 2004; Modigh et al. 2021) have drawn on observational designs or correlational studies, which are used to infer conclusions in many co-design studies. In such cases, associations between co-design and improved patient outcomes are discovered but causation cannot be asserted with any level of certainty. For example, some improvements in

satisfaction or social networks may result from other reforms undertaken at the same time and not be attributed to participation in co-design.

More recent contributions (Ezaydi et al., 2023; Thomas, Lynch, & Spencer, 2021) focus on systematic reviews. However, these reviews tend to synthesise highly heterogeneous studies, using different definitions of co-design, different outcome measures, and different levels of user involvement. Therefore, while systematic in collection, the compilation of methodologically diverse studies poses serious concerns regarding internal validity and comparability.

Despite having insightful conceptual frameworks, a limitation arises in studies like Bombard et al. (2018) and Donetto et al. (2015), due to the lack of sufficient longitudinal data to assess the sustainability of co-design outcomes over time. Together with these studies, Scanlan et al. (2020) and Sheikan et al. (2023), highlight positive effects but relying only on pilot studies or short-term evaluations, which risks overlooking the longer-term complexities and systems involved in the adoption of co-design.

The over-reliance on self-reported data by service users and professionals in Batalden et al. (2016), Clarke et al. (2017) and Palumbo (2016) raised another methodological concern. Although these subjective accounts are valuable for interpretive purposes, they are prone to social desirability bias, especially in settings where co-design is promoted as a normative good.

Finally, although many studies advocate for the democratizing effects of co-design (Beckett et al., 2018; Robert, 2013; Tollyfield, 2014), few critically question power dynamics through their methodologies. Participatory processes are described positively, but there is limited empirical measurement of shifts in actual decision-making authority or power redistribution.

2.5.4 Challenges

To adequately evaluate co-design, it is imperative to explore existing literature featuring the perspectives and experiences of all relevant stakeholders. Grasping an understanding of the elements which influence the validity of past co-design approaches can bring further insight into their practical implications.

The application of a critical approach termed 'constructive disenchantment' is necessary to navigate through the complexities and potential pitfalls associated with co-design. This approach is meant to challenge the unrealistic expectations of existing models of care to then focus more effectively on the actual necessities of the service users for whom the service was originally designed. Failure to grasp its principles can result in a general disillusionment of the stakeholders involved, thereby leading to mistrust and suboptimal outcomes. The implementation of the outcomes derived from a co-design approach into practice faces multiple challenges, particularly if these outcomes aspire to idealistic concepts which are bound to interact with real world constraints (Dudau, Glennon & Verschuere, 2019; Onie et al., 2023).

Enabling meaningful participation of service users as co-designers can prove to be particularly challenging (Donetto et al., 2015; Locock et al., 2014). The co-design approach aims to transform the existing hierarchal dynamics amongst the various stakeholders and, if executed effectively, this should foster a collective ownership and catalyse changes in behaviour and values. However, when the engagement of service users and family members regresses to mere consultation, the opportunity for transformative impact diminishes significantly thus,

maintaining a commitment to evidenced co-design practices, is essential for achieving equitable and effective service delivery.

Despite all the data the NHS has collected over the past decade regarding patient experiences, the translation of this extensive information into meaningful service improvements has not been consistently achieved and remains a considerable challenge (Coulter et al., 2014).

Understanding the perspectives of service users, carers, and staff is vital for co-designing potential improvements. Nevertheless, various challenges persist, including governance issues, high staff turnover, and a lack of management support (Bowen et al., 2010; Bowen et al., 2013; Piper et al., 2012). Furthermore, aside from the logistical challenges, such as securing the necessary budgets, co-design is often perceived as an additional burden by the employees, who find it hard to find time to fit additional duties to their already pressurised schedules (Larkin, Boden & Newton, 2015; Proctor et al., 2023).

The shortcomings in current organizational structures often fail to facilitate equitable involvement for seldom-heard groups, which may prevent effective engagement (Chauhan et al., 2021; Ní Shé et al., 2018). The absence of diverse representation in co-design risks reinforcing existing biases (Moll et al., 2020; Ní Shé et al., 2019). A successful co-design process requires particular attention to be placed on the candidate selection process which need to be purposive. Participants should ideally be experts by experience, who know the field of interest well enough to provide constructive contributions. Furthermore, it is imperative for the chosen participants to invest time in relationship building, to destabilize any preexisting professional hierarchies and cultural barriers (Zechmeister-Koss et al., 2023). Care-relationships in long-term care are fundamental to the quality of care provided, and co-

design implementations must recognize the importance of such relationship building, and value their complexities and the tensions therein (Heerings et al., 2022; Heerings et al., 2020; Strandås & Bondas, 2018; Topor & Ljunberg, 2016).

Power imbalances and a failure to recognize the value of lived experience voices pose notable barriers to effective involvement (Bird et al., 2020; Larkin, Boden & Newton, 2015). Although literature on shifts in these power relations during co-design is sparse (Donetto et al., 2015), prior studies on mental health service co-design suggest that power relations can evolve, facilitating uninhibited sharing of opinions across professional and non-professional roles (Gillard et al., 2010). Overcoming entrenched institutional decision-making ownership and implicit resistance from key leadership further complicate the implementation of equitable collaborations (Bosak et al., 2024).

The establishment and sustainability of co-design models necessitate robust infrastructural support—physical, social, human, and economic—which is often inadequately met (Palmer et al., 2023). Without proper organizational structures, such as regular staff meetings or reflective practice groups, staff engagement in co-design initiatives remains challenging (McAllister et al., 2021). Even when opportunities for participation arise, clinicians frequently encounter barriers related to shift patterns and staffing levels, resulting in disproportionate responsibility being placed on service users (Donetto et al., 2015).

The rushed nature of many projects can inhibit genuine dialogue and fail to accommodate the diverse needs of vital community members (O'Brien et al., 2021; Palmer et al., 2019). The nature of co-design processes is quite lengthy, in fact this presents significant barriers to sustained involvement, participant motivation may subside, and individuals may withdraw

due to various factors sum of which can easily be legitimate (Donetto et al., 2015). Surveys conducted within occupational therapy and nursing programs in Australia and New Zealand indicate that while the involvement of individuals with lived experience of mental distress is valued, it is frequently limited to singular sessions lacking depth and continuity (Happell et al., 2015; Scanlan et al., 2020). Furthermore, while care models, such as person-centred care (Claes et al., 2010) and recovery-oriented care (Farone, 2006), advocate for client engagement, the implementation of values such as self-determination may conflict with harm prevention principles. Divergent perspectives from informal carers, clients, and professionals further complicate the care relationship (Heerings et al., 2020; Pols, Althoff & Bransen, 2017).

Despite the evident importance of the ethical considerations surrounding mental health co-design these are frequently underestimated. Issues related to, consent, anonymity, confidentiality, power dynamics, and data ownership are not uncommon. Potential re-traumatization can also occur if participants are required to sustainably narrate their trauma without the necessary support or if the research environment is not trauma informed. Due to this service users are prone to face vulnerabilities stemming from past trauma or conditions such as paranoia, which render them apprehensive about participating in processes that require recording of conversations (Larkin, Boden & Newton, 2015). Historical negative experiences with mental health services can result in reluctance to engage in co-design initiatives (Pearce et al., 2022; Tindall et al., 2021). Professionals must navigate the delicate balance between protecting vulnerable participants and empowering them within the context of co-design (Mulvale et al., 2019).

Co-design program effectiveness relies on robust leadership, clearly defined objectives, and sustained involvement from service users, yet the systemic complexities and sensitivities

inherent in mental health care often limit genuine participation (Dixon-Woods et al., 2011; Tambuyzer & van Audenhove, 2015). The reality remains that many initiatives suffer from tokenistic engagement, wherein service users exert minimal influence over critical decisions impacting their care, this despite widespread advocacy for user engagement in care practices (Beresford, 2013; WHO, 2013; Rose & Kalathil, 2019).

Although the reviewed literature provides a thorough and critical summary of the main barriers inherent to co-design, there are significant methodological weaknesses in the evidence base upon which it draws.

Several influential studies (Donetto et al., 2015; Dudau, Glennon & Verschuere, 2019; Locock et al., 2014) adopt largely qualitative, descriptive methodologies. Although these are valuable for depth and context sensitivity, they tend to rely heavily on retrospective reflections, single-site case studies, or small participant samples, limiting the capacity for broader generalization or causal inference.

Across studies such as Bowen et al. (2010, 2013) and Piper et al. (2012), a common issue is their reliance on evaluative reports linked to specific institutional contexts, most often the NHS. Although this usually bring a rich textual description of context, the methodology of these studies often does not control for external variables influencing co-design outcomes (e.g., parallel policy reforms), making attribution of results to co-design practices alone problematic.

Similarly, studies investigating the participation of seldom-heard groups through exploratory interviews or surveys, like Moll et al. (2020) and Ní Shé et al. (2018, 2019), help address some of the equity gaps. Yet, some of these studies do not restrict or outline framing techniques for

their participant selection which poses significant issues regarding bias and fair representation of marginalized voices.

Work like Zechmeister-Koss et al. (2023) stresses the importance of purposive participant selection in co-design. However, much of the surrounding literature evaluated here does not provide detailed accounts of recruitment or retention strategies, which weakens claims about inclusivity and diversity.

Ethical considerations are acknowledged in studies such as Larkin, Boden and Newton (2015) and Pearce et al. (2022), but most reports rely on self-reported participant experiences without triangulation through observational or longitudinal methods. This raises validity concerns, especially when investigating sensitive topics like power imbalances or trauma impacts during participation.

Finally, studies emphasizing leadership and organisational structures for sustainable co-design (e.g., Dixon-Woods et al., 2011; McAllister et al., 2021; Palmer et al., 2023) tend to be conceptual or based on scoping reviews, meaning practical implementation evidence remains thin.

Regardless of the various challenges in effective co-design, this approach offers a unique opportunity to transform mental health services by unifying diverse perspectives and expertise. Addressing challenges related to stakeholder engagement, power dynamics, ethical considerations and resource allocation is crucial for the successful implementation of co-design processes. Commitment towards authentic collaboration, together with a recognition of the complexities involved, will likely lead to mental health care which is person-centred and fair. While the journey towards meaningful co-design presents significant challenges, the

potential benefits for service users, carers, professionals, and the broader healthcare system makes it all worthwhile.

2.5.5 The importance of stakeholders' perspectives

As extensively covered in previous sections, there is an increasing interest and move towards a more collaborative and participatory approach in the provision of mental health services. At the heart of this shift in focus is the co-design process which includes a broad range of stakeholders such as healthcare professionals, managers, and service users.

To establish effective mental health interventions, it is paramount to take into consideration a variety of stakeholder opinions. This collaborative tactic enables the development of solutions that were previously potentially overlooked and considers their relative importance within specific groups. A comparison and merging of different points of view helps to address the core issue of understanding the stakeholders' focus and priorities. Such approach not only broadens the scope of the analysis but also augments the understanding of the varying needs and values within stakeholder groups (Minogue, 2005).

This section intends to consider three critical perspectives from which the co-design processes and practice in mental health services may be viewed, providing an understanding of the dynamics involved in the practice of co-design.

Healthcare Professionals

Understanding the perceptions of healthcare professionals on how they see their roles and their input within a co-design approach is fundamental for establishing a nurturing and collaborative atmosphere. They can bring to the table unique insights and competences which are indispensable for the development of services and, through their involvement in the design process, they can significantly enhance service relevance and outcomes, thereby promoting a more person-centred approach to mental health care.

Several studies concur that healthcare professionals describe co-design processes as a transformative experience. The process is considered as highly informative and impactful for fostering understanding, as narratives from lived experiences enhance the providers' understanding of service users and enable them to relate and to emphatically consider their perspectives, resulting in a more profound comprehension of lived experiences (Chisholm et al., 2018; Hall, 2023; McAllister et al., 2021; Springham & Robert, 2015; Whitelaw et al., 2023).

Several benefits have also been reported by healthcare professionals, including enjoyment, achievement and a sense of pride and belonging which might be a contributing factor to their perspective on co-design. Through the feedback and evaluations of service users in the design process, involved healthcare professionals have gained the ability to understand how their behaviour and attitudes are perceived by service users, thereby enhancing their communication effectiveness within intervention (McAllister et al., 2021; Tindall et al., 2021; Vella-Brodrick et al., 2023; Whitelaw et al., 2023).

The collaborative atmosphere of the co-design process has been perceived by healthcare professionals as accessible, intentionally structured, and conducive to personal expression.

This environment cultivates an appreciation for diverse perspectives, meant to ensure that all participants feel valued and heard. These factors are perceived as important drivers as they aid self-efficacy and achievements as well as acceptance towards more inclusive discussions that moderates the power of any one individual point of view (Chisholm et al., 2018; Hall, 2023; McAllister et al., 2021; Whitelaw et al., 2023).

Regardless of the various studies on the perspectives of healthcare professionals on co-design, most document the experiences of those who have experienced the process and its perceived advantages, highlighting the transformation and collaboration the process brings with it. Research also demonstrates the existence of some challenges brought about by this approach, including discomfort through imbalance in power dynamics, limited resources, and the intricacies in finding a balance between different stakeholders' perspectives (Cooper et al., 2023; Gartshore, 2018; Hall et al., 2023).

Healthcare professionals have expressed apprehensions connected to the possibility that co-design may accidentally place more focus on the perspectives of service users, possibly overthrowing the need for, and importance, of achieving a balanced platform where all viewpoints from different stakeholders are given the same importance. This perceived excessive focus on the perspectives of service users has resulted in discomfort among healthcare professionals, especially within imbalances of power dynamics which can provoke feelings of helplessness and discouragement (Cooper et al., 2023; Gartshore, 2018).

Moreover, some healthcare professionals allege feeling pressured by management to take part in the design process. From their perspective, such an attempt might seem to amplify existing strains as well as creating new ones that could hinder open communication, thereby

forfeiting collaborative efforts. While some healthcare professionals admit that they have gained some form of increased understanding about their role, there is still a sense of uncertainty about power differentials, suggesting that a legacy of enduring power inequalities still exists in the healthcare system. The operational constraints depicted, such as lack of time from staff and the voluntary nature of their involvement, poses the risk of fostering annoying conversations as well as disregarding any reasonable action coming from those concerns (Bowen et al., 2013; Chisholm et al., 2018).

There is still limited understanding of how healthcare professionals perceive co-design prior to their embarking in this process. Past beliefs and assumptions could fundamentally impact the implementation and outcomes of co-design efforts like apprehension around sustainability, tokenism, power imbalances and professional expectations, which may all serve as barriers even before such efforts are put into practice (Hall et al., 2023; Vella-Brodrick et al., 2023; Vennik et al., 2016).

In exploring the experiences and perceptions of people involved in the co-design of a new service for people with high healthcare service utilisation, McGowan et al. (2024), highlighted those positive aspects, such as the emergence of a common purpose, and an innate motivation to participate in the co-design initiative, were reported. However, the study, focused solely on healthcare professionals in one co-design initiative which was being implemented by one of the thirty-one primary health networks in Tasmania, thereby limiting its transferability. Furthermore, unlike this study, the participants had previous experience with co-design initiatives, therefore this might have enabled them to use their past experience to ensure the success of the initiative, and the authors were therefore unable to explore the

perspectives and possible misconceptions of the participants prior to any involvement in a co-design initiative.

This study aims to fill this gap by looking into the perspectives of healthcare professionals on co-design in Malta, prior to their participating in the process. More specifically, this study seeks to understand how these initial perspectives inform us about the possibilities for healthcare professionals to act as proponents or as barriers in the integration of co-design methodologies in the planning of mental health services.

Managers and Leaders

Current research provides limited understanding of how co-design is perceived by management, raising concerns that, when enacted, it may serve more as a marketing ploy rather than being driven by genuine efforts to achieve meaningful outcomes. Understanding how mental health management in Malta perceives the concept of co-design, and whether they believe service users can provide valuable insights that complement their tacit knowledge, is crucial. This understanding can reveal whether management is likely to facilitate the implementation of co-design in a way that delivers tangible results or merely use it to project an image of inclusivity.

Managers and leaders play a key role in shaping organizational culture and establishing policies that either promote or hinder service user involvement, making their perspectives critical to the success and sustainability of co-design initiatives. Their viewpoints help uncover challenges and opportunities in integrating service user input into strategic and operational frameworks. Research suggests that while management often views co-design as a valuable

platform for gaining insights into service delivery, it also exposes the limitations and unconscious constructs managers adopt (McGowan et al., 2024; Tindall et al., 2021). Managers often describe the sharing of personal experiences during co-design as a 'privilege' and an 'incredibly moving' encounter that enriches their expertise, leading to innovative care models and enhanced quality standards. Yet, despite recognizing these benefits, managers acknowledge that service user voices remain underrepresented in practice (McAllister et al., 2021; McGowan et al., 2024).

The incorporation of Experts-by-Experience (EBE) in the co-design process brings to light a paradox. On one hand, managers recognize the value of service user input but express concerns about client vulnerabilities and the skills required for effective participation. Service users are expected to represent the 'average' service user, yet managers often doubt whether such individuals possess the necessary competencies for meaningful engagement (Rose & Thornicroft, 2010; Visser et al., 2024). This creates a duality that raises inclusivity concerns, as those without adequate skills may be excluded, undermining the authenticity of their involvement and diminishing their contributions to service design (Armstrong et al., 2013; Bombard et al., 2018; Cox et al., 2022; McGowan et al., 2024; Ocloo, 2016; Ocloo et al., 2021).

Managers also express the need to occasionally exclude service users from discussions to resolve conflicts and achieve alignment. This reflects an implicit belief that service users' contributions are less valuable during the design phase and more relevant in later stages, such as experimentation and implementation. This practice risks reducing service user involvement to mere consultation, fostering tokenism rather than meaningful collaboration. It may also confine service user input to less controversial areas, reflecting paternalistic attitudes toward

the resilience of individuals with mental health experiences (Bosak et al., 2024; Happell et al., 2015; McGowan et al., 2024; Mulvale, 2024; Visser et al., 2024; Watson, 2022).

Further, managers often rely on their professional knowledge and clinical experiences to assume an understanding of service user needs, applying protective discourses on sensitive issues. This approach risks introducing personal biases, perpetuating power imbalances, and diminishing the transformative potential of co-design (Albert et al., 2023; Bombard et al., 2018; Farr, 2018; Ocloo et al., 2020). Additionally, persistent stigma toward mental health witness within healthcare environments during co-design processes, further exacerbates the challenges of co-design (Henderson et al., 2014; Knaak, Mantler & Szeto, 2017; Nguyen et al., 2019).

Although some managers maintain a predominantly positive view of co-design's effectiveness, their detachment from its core activities and the slow pace of institutional change may contribute to a divergence in perspectives. This contrasts with the more critical evaluations of other stakeholders, who are often more attuned to the complexities of implementing co-design within mental health services (Bowen et al., 2013; Nguyen et al., 2019).

Whilst exploring the considerations of healthcare professionals and managers on the involvement of patients and public in care pathway development, Visser et al. (2024) found that the concept of expert by experience frames the involvement of service users as necessary to fully understand their needs. However, for services users to offer a valid contribution, they would need a certain degree of skills and competences. Furthermore, professionals tend to believe that they know best, due to their expertise related reasoning. The author uses these

discourses to explain why co-design and co-production are sometimes postponed or reduced to a tokenistic implementation.

However, the transferability of their findings depends firmly on the similarity of the context, since the study was based entirely on a single case in one rehabilitation centre. In fact, they recommended to repeat the study in other organisations to collect further data and confirm or refute the transferability of their findings.

This study aims to address the gap in understanding management's perspectives on co-design, exploring whether they believe it could benefit Maltese mental health services or whether their beliefs and practices hinder its meaningful implementation. By critically examining management's views, the study seeks to illuminate whether co-design is being approached as a transformative process or merely as a tool for public relations.

Service users

Mental health service users have been shown to value their inclusion and contribution to designing mental health services, believing that it leads to a service which is focused directly to their specific needs. Despite known obstacles, service users see co-design as a beneficial collaboration which has the potential to improve communication and enhance the quality of the mental health services provided. Their involvement in co-design initiatives makes them feel empowered, heard, and appreciated. Their personal interest could be the key to circumventing obstacles created by misinformation and unwarranted prejudice.

The co-design methodology has been shown to significantly augment the sense of value of those involved in the collaborative processes. Service users indicate that they feel invited to

engage in meaningful discussions, which foster a warm environment in which diverse perspectives are acknowledged and valued (Bowen et al., 2013; Cooper et al., 2015; Mulvale, 2024). Through this inclusive approach, they feel that their voices are being validated and that a lot of weight was placed on respect and equality, leading them towards an increased overall engagement among all the stakeholders. Service users have reported feeling greater dignity and respect, reinforced by an environment conducive to collaboration (Faulkner et al., 2021; Kehoe, 2024; Lwembe et al., 2017; Odejimi et al., 2021; Pocobello et al., 2020; Watson, 2022).

The impact of this participatory approach extends beyond mere engagement; service users expressed feeling significant enhancement of their self-esteem, dignity, and sense of control over their circumstances (Bosak et al., 2024; Hassan et al., 2020; Jones and Pietila, 2020; Watson, 2022; Lwembe et al., 2017; Odejimi et al., 2021; Pocobello et al., 2020). They shared that they view such methodologies as yielding substantial improvements in their well-being outcomes, including boosted confidence and decreased social isolation (Blickem, 2013; Chesterman & Bray, 2018; Hassan et al., 2020; Illarregi et al., 2023; McEvoy et al., 2023; Muir, 2024; Strachan, Wright & Hancock, 2007; Swift, 2017). These insights emphasize the role of participatory methodologies in enhancing service user engagement, promoting not only personal growth but also improving perceptions of care within the mental health service system (Gartshore, 2018).

Unfortunately, despite the documented evidence of the benefits of co-design initiatives, certain clients still describe their involvement as limited to providing feedback, and that they are not involved in the actual design process. This perception could reflect how certain implementations of co-design lack the necessary commitment from management (Bowen et al., 2013; Heslop, Cranwell & Burton, 2019; Kehoe, 2024). Additionally, factors like decreased

level of self-confidence brought about by depression and anxiety disorders leading them to feel uneasy about engaging with new group due to past negative experiences have also been reported by service users. Many service users participating in co-design process struggle to articulate constructive feedback towards the services even when they are prompted to do so by the facilitators, which is further evidence of a barrier to meaningful involvement (Blickem, 2013; Chesterman & Bray, 2018; Hall et al., 2023).

Both McGowan et al. (2024) and Visser et al. (2024) highlight potential hindrances to the co-design process, such as the self-protection and bureaucracy. Visser et al. (2024), continued to suggest a few strategies to mitigate the effect of the identified hindrances. These included, the training the stakeholders, and ensuring that a safe space is created for all stakeholders involved. However, aside from the limitations already mentioned above, these studies suffered from limited or no involvement of service users, whose perspective, therefore, wasn't explored.

Whilst understanding stakeholder perspectives regarding barriers and facilitators to integration of mental health services into primary care settings in Northern Iraq, Nguyen et al., (2019), reported that lack of private space, human resources, government support, and support by the family coupled with client logistical challenges were identified as potential issues to integration. However, given the sudden changes in the political economic social technological legal and environmental factors of the country at the time of the study, and the fact that the study involved only a sample of clinics from one region, the results cannot be presumed as generalisable.

In their paper, Tindall et al., (2021), identified lessons in an effort to inform future co-design initiatives, and add growth and acceptance of the co-design movement.

The paper highlighted multiple possible hindrances including the fact that:

- attempting a co-design implementation without acknowledging the need for a structural reform of the mental health system would be unproductive,
- a co-design implementation requires more time, and time constraints will not promote a successful implementation,
- role delineation is rarely well defined, and participants will often transcend their defined roles, this can be misconstrued as defiance.
- power dynamics had to be mitigated by regular reflective sessions to ensure they were not hindering the behaviours or sharing of experiences since a decision had been taken by the organisation, prior to initiating the process, that a clinician would act as line manager. The paper proceeded to highlight what could help lead a co-design initiative to a successful implementation, these included:
 - Allowing time for the participants to get to know each other, thereby enabling a relationship of trust to form
 - Ensuring that all participants, including experts by experience were reimbursed for their time and contributions.
 - Using pre and post session reflections to realign to the shared vision of the co-design initiatives, despite looming deadlines
 - Considering what is being communicated beyond words, to ensure that any frustration or distress is effectively and empathically dealt with.

This study was very thorough in its conclusions; however, the whole study is based solely on the co-design experience of four people (a clinician, a service user, a care worker, and a project manager), in one co-design implementation in one setting. This limits its transferability to other contexts and scenarios.

Gaining insight into how service users within the Maltese mental health community perceive the potential of co-design applications, is crucial for determining their willingness to embrace the concept and therefore contribute actively to its application in practice. By exploring the perspectives of clients one can better assess their openness and capacity to participate. This study aims to address this gap in the Maltese mental health service planning, to better understand whether the services users are able participate effectively and are willing to do so.

Despite its widespread recognition overseas for enhancing service user engagement, fostering empowerment, and improving care outcomes, the Maltese mental health system remains foreign to the practical application of co-design mental health service planning.

2.6 Conclusion

The aim of this study is to explore the perspectives of various stakeholder within the Maltese mental health community on the concept of co-design to evaluate whether the implementation of this approach would be feasible in Malta. From the literature review process, it becomes tangible that there is a gap in understanding the perspectives of stakeholders on co-design before it is implemented. This study seeks to fill this gap and enhance the broader understanding of co-design in mental health services. It will explore the

views of service users and other stakeholders on the whether a co-design process would be beneficial in mental health services planning in Malta and what would be the potential hindrances to its implementation. This study will also explore how service users and healthcare professionals view their inclusion in a co-design process as well as the point of view of management on whether service users are ready and able to participate in this process.

Even though internationally the benefits of co-design have received much recognition, Malta has yet to adopt this approach. By addressing these gaps and understanding stakeholder concerns, this study aims to help in overcoming barriers and establishing the foundations for a more inclusive and effective mental health service model in Malta, in alignment with international best practices.

CHAPTER 3: METHODOLOGY

3.1 Introduction

This chapter gives a broad outline of the application of the methodological framework throughout its implementation. It lays out the aims and objectives of the study, as well as the operational definitions applicable to the research. It provides the philosophical framework on which the study was based and a detailed description of the research design. The sampling technique and the demographic characteristics of the participants are also discussed in detail. It expands to cover the data collection processes, outlining data analysis to ensure transparency in the analytical processes used, and ethical considerations to ensure the integrity and well-being of the participants throughout the study. In conclusion, this chapter discusses the importance of quality assessment and reflexivity to ensure solid research findings.

3.2 Operational Definitions

The term '*perspectives*' in this study features viewpoints, attitudes, and ways of considering co-design, shaped by the participants experiences, beliefs, and knowledge which influence how they understand or interpret this concept.

The term '*co-design*' refers to a participatory and collaborative approach that incorporates the perspectives and lived experiences of both users and professionals in the design and development of services.

The term '*stakeholders*' refers to caregivers who work within mental health services; individuals who make use of mental health services; and individuals in management positions with such services.

3.3 Aim of the Study and Research Questions

This study explored the perspectives of stakeholders on co-design of mental health services planning in Malta. It sought to understand how service users and healthcare professionals perceive their role and inclusion in service design, how managers perceive the involvement of service users in designing services and explored what could be the challenges and benefits that, according to stakeholders, could be faced whilst implementing a co-design approach.

The following are the research questions used to achieve the research aim:

- What is the perspective of service users and healthcare professionals in relation to their inclusion and contribution to designing mental health services?
- How does management view the inclusion of service users in the design of mental health services?
- What do service users and other stakeholders perceive as being the potential hindrances to an implementation of a co-design approach and do they believe it would be beneficial?

3.4 Research Paradigm and Philosophical Underpinning

3.4.1 Interpretivism and Social Constructivism

Given the interpretive nature of this inquiry, a qualitative case study approach was selected for this study as it facilitates an in-depth exploration of personal narrative and experiences that shape the lived experiences, thereby yielding rich, in-dept insights into their emotional and psychological landscapes, allowing for a nuanced understanding of the complexities within this specific context, something which is otherwise not achievable through a quantitative methodology (Creswell & Poth, 2018; Liamputtong, 2009; Olson, Schultz, & Young, 2015).

This alignment between the study's objectives and the qualitative approach underscores the relevance of interpretive frameworks in elucidating the perspectives of stakeholders who work in and use mental health services in relation to co-design, providing an insight on their understanding, relational dynamics and perceived challenges in its adoption within the planning of mental health services, ultimately contributing to the broader discourse on different perspectives and lived experiences within mental health contexts.

Given the complexity of stakeholder interactions and the subjective nature of co-design experiences, this research is guided by an interpretivist paradigm. The interpretivist paradigm emphasizes the importance of context, which is central to case studies. Researchers must figure out how certain contextual features, such as social, political, and historical factors, affect participants' experiences (Mills, Durepos, & Wiebe, 2010). It assumes that reality is

socially constructed, and that knowledge is developed through the individual experiences and interactions of the members of society (Creswell & Poth, 2018; Dilthey, 1991).

Social Constructivism serves as a philosophical underpinning of the interpretivist paradigm, highlighting the function of interaction, context, and co-creation in shaping these individual human experiences, aligning with the interpretive paradigm's focus on subjective experiences, as it views knowledge as socially and contextually co-created. It affirms that social discourse is fuelled from the production of knowledge (Denzin & Lincoln, 2011; Vygotsky, 1978). Researchers employing this underpinning focus on how individuals and groups interact and collaborate in creating and sharing meaning, examining relations, communication processes, and the underlying culture. Social constructivism emphasizes the constructed nature of reality together with the subjective nature of human experiences, validating the idea that reality differs from person to person and that sociocultural context, history, and society are key determinants for views and meanings (Creswell & Poth, 2018; Vygotsky, 1978).

The interpretive paradigm, together with the influence of social constructivism that influences how we think about knowledge and learning, aligns with this qualitative research as it seeks to explore meaning rather than test hypotheses. This approach in case study design focuses on comprehension of personal insights and experiences, thus integrating the involvement of the researcher and the participants and acknowledging that each stakeholder may have varying perspectives on co-design influenced by their lived experiences. It enables better understanding of the phenomena under study as it is based on the lived experiences and contexts of the participants (Burkitt, 1996; Stake, 1995).

3.4.2 Case Study Design

Within sociological research, the case study design is a renowned technique that facilitates the researcher in forming a strong knowledge base that allows for an assessment of complex theoretical variable and principles. This research design contributes significantly to both professional practice and the advancement of scientific understanding (Flyvbjerg, 2006; McCutcheon & Meredith, 1993; Yin, 2014).

A defining feature of case studies is their ability to provide analysis that is relevant beyond the single case that is being studied, providing valuable insights to a broader context (Mills, Durepos, & Wiebe, 2010; Stake, 1995). This design proves to be highly useful when addressing research questions on what, why, and how (Crowe et al., 2011). Specifically, in the context of understanding the perspectives of stakeholders on the pre-determinants of co-design in mental health services in Malta, a case study can provide critical insights that can inform implementation strategies (Beecroft et al., 2022; Widner, Woolcock & Nieto, 2022).

This study adopted a single embedded case study design with within-case analysis, enabling an in-depth exploration of diverse stakeholder perspectives on co-design within Maltese mental health services without cross-site comparison (Yin, 2014).

Qualitative researchers tend to avoid generalising because each case has its own specific context. For this reason, this study carefully selected cases that represent broader patterns within the Maltese mental health system, while acknowledging that direct generalisation across all services is limited (Creswell & Poth, 2018; Yin, 2014). The methodological approach outlined by Yin (2014) was particularly suited to this research because of its emphasis on

rigorous case design, data triangulation, and the capacity to address real-world contextual complexities.

Case study research carries the responsibility of clarifying descriptions and broadening interpretations in accordance with constructivist epistemology, advocating for the provision of substantive raw material for readers to develop their own generalizations. This approach highlights phenomena that typically create public interest, particularly concerning places, events, and individuals (Mills, Durepos, & Wiebe, 2010). The primary objective of research shifts from uncovering the external reality to refining representations of the constructed reality and improving the rational reality through building robust representations that can survive critical scrutiny (Stake, 1995).

3.4.3 Theoretical Framework: Co-Design

The main theoretical framework that this study is based upon is The Four Key Elements of Co-Design (Bate & Robert, 2007; Donetto et al., 2015; Sanders & Stapper, 2008). The Four Key Elements—engagement, relationship building, capacity building, and co-creation—offer a structured yet flexible framework for ethical and inclusive participation. Originally developed to support collaborative practices in diverse and marginalised communities, this framework emphasises mutual respect, shared power, and the importance of context in shaping participation. It was selected as the primary theoretical lens for the study as it closely aligned with the research aim of exploring stakeholder perspectives within a context where co-design is yet to be formalised. Its relational and practical focus offered a solid basis for mapping out

the emotional, systemic and cultural preparedness of Malta's mental health services for participatory reform.

Additionally, this study drew on three other theoretical frameworks: Arnstein's Ladder of Participation (Arnstein, 1969), Systems Theory (Meadows, 2008), and Critical Theory (Horkheimer, 1972). The study chose these frameworks as they have previously been used to evaluate participatory processes in the planning or development of mental health services and include a focus on the process of stakeholder engagement.

Arnstein's Ladder of Participation provides a useful framework for understanding the degree of power-sharing in participatory activities. It describes types of participation in terms of eight rungs, ranging from non-participation to citizen control. It allows exploration of the positioning of stakeholders, predominantly service users, in terms of their influence on decision-making. It informed whether participation in co-design was tokenistic or meaningful.

Systems Theory provides a framework through which the interconnections between people, structure and processes within complex systems, such as mental health services, can be understood. It conceptualises organisations as dynamic systems, whereby alterations to one element of an organisation inevitably impact upon the whole.

Critical Theory aims at identifying and challenging structural inequities, power structures, and social injustices within institutions. This theory carries an emancipatory imperative, targeting the understanding of inequalities and oppression, as well as transforming the world through amplifying marginalised voices and questioning dominant ideologies.

These four complementary frameworks were used for this study as they each offered a different perspective which provided a richer understanding of co-design that no single theory could offer alone. Through Arnstein's Ladder of Participation, stakeholder power was evaluated, distinguishing between tokenism and genuine participation. The Four Key Elements of Co-Design assessed relationship building, capacity building and co-creation for ethical and inclusive engagement. Systems Theory considered the roles, structures and processes that form and interact as part of services while Critical Theory exposed hidden power dynamics and systemic marginalisation.

Together, these frameworks informed the study's research questions, data analysis, and interpretation by providing a clear lens through which participation, power dynamics, and co-design practices could be critically examined.

3.5 Data Collection Methods

3.5.1 Qualitative Methods: Semi-Structure Interviews

Given the study's interpretivist paradigm and qualitative approach, data was collected through semi-structured interviews with key stakeholders. Constructivism suggests that interviews are not just data gathering methods but also social encounters that produce knowledge (Mills, Durepos, & Wiebe, 2010).

To understand participants lived experiences, researchers must engage with them on a deeper level, listening and probing carefully throughout the interview (Ritchie, & Lewis, 2003; Yin, 2011).

A flexible approach was taken for interview scheduling, accommodating participants in terms of place and time. Interviews were held in person, allocating one hour to have enough time for exploration. The semi-structured format of the interviews helped maintain focus on key thematic areas of inquiry and provided flexibility in engaging with responses (Creswell, 2015). A Maltese and English version of an interview guide was prepared containing open-ended questions. Interviews were audio-recorded, following written and verbal consent, and transcribed verbatim in their spoken languages, with Maltese ones translated into English.

These interviews explored participants lived experiences and their perceptions and views of the co-design process. Participants were given the possibility for clarifications when their reply diverged from the question asked, thus allowing the emergence of new insights during data collection (Yin, 2011). Any unanswered questions were put forward again by the research to ensure the necessary information was collected. This allowed requests for clarification of any concepts which left room for misinterpretation (Creswell, 2012). Recordings were transferred to a password protected laptop owned by the researcher and kept on locked storage. The interviews were then translated, transcribed, interpreted, and represented into readable and meaningful text (Bailey, 2008).

3.5.2 Sampling Strategy

Participants were strategically chosen from different sectors to provide access to unique viewpoints and experiences that are relevant to the phenomenon under investigation (Yin, 2011). The researcher ensured that each stakeholder group was represented to ensure the build-up of complexity within the research (Creswell, 2015). The groups were composed of service users; managers; and healthcare professionals (nurse, occupational therapist, social worker, lead carer etc). A purposeful sample population was selected within the mental health service setting, to enable a deeper understanding of what factors are perceived as affecting a successful implementation of a co-design approach (Yin, 2011). Clear sampling objectives were established which included identifying the population of interest, the required sample size, and inclusion and exclusion criteria meant to increase the relevance of the findings of the study.

Participants for the study were recruited from four separate entities, to cover as vast a spectrum as possible for richness of data and to gain perspectives from different services. Intermediaries approached potential study participants and provided information letters, informing them that their participation was voluntary and can be withdrawn at any time. Once participants were identified, the intermediaries liaised with the researcher for co-ordinating the logistics of the interviews. Interviews were scheduled for convenience and accessibility. A consent form was presented to all participants to sign and researcher explained that any information shared would remain confidential and anonymous. No details of potential participants were given to the researcher prior to the interview phase, including those participants who might have refused to be part of the study.

Twenty-two (23) participants were recruited as specified in the inclusion and exclusion criteria outline in Table 3.2. The aim was to recruit twenty-four (24) participants, but one of the service users of Richmond Foundation withdrew her consent following the interview, so her data was deleted and not used for this study. The participants required to be over 18 years of age and well acquainted with mental health services in Malta from either a service user or professional aspect (see Table 3.1)

Table 3. 1 - Participants recruited

Entity	Management	Professionals	Services Users	Total
Mental Health Hospital	1	2	3	6
NGO	1	2	2	5
Private company running a psycho-geriatric home	1	2	3	6
Private company running a community home for persons with mental health conditions	1	2	3	6
Total	4	8	11	23

Table 3. 2 - Inclusion and Exclusion Criteria of Participants

Inclusion	Exclusion
Over the age of 18 years	Under the age of 18 years
Professionals who have been working in mental health service for a minimum of 2 years	Professionals who have been working in mental health services for less than 2 years
Service users who have been diagnosed with a mental health condition for at least 2 years	Persons working in mental health services on a voluntary basis
	Service users who have been using mental health services for less than 2 years

3.6 Data Analysis Approach

Given the study's aim to explore multiple stakeholder perspectives within the bounded context of Maltese mental health services, a within-case analysis was employed, following the methodological principles articulated by Yin (2014). In other words, the study treated the Maltese mental health system as a single case incorporating multiple embedded units of analysis, with a focus on exploring the internal complexity of the case by exploring how service users, healthcare professionals, and managers understood the concept and practice of co-design across different sites. This approach is consistent with Yin's (2014) delineation of a case study method as ideally suited to understand a real-world case in depth, especially in cases where you look at how subunits, which he describes as distinct but interrelated groups located within the same bounded context, work within a particular context. By focusing on variation within the case, rather than across separate cases, the study was able to generate contextually rich, nuanced, and practice-based insights into the systemic, relational, and organisational factors shaping co-design in an emergent context.

The validated transcripts were reviewed several times to ensure adequate familiarisation with data. Familiarisation is critical for centering the perspectives of the participants in the analytical process. Repeated readings enhance the understanding of the narratives and reveal the interconnectedness of various interview segments, allowing the identification of initial patterns and themes (Mills, Durepos, & Wiebe, 2010; Stake, 1995). Following familiarisation, the interview transcripts of each participant were placed into a file named using the encrypted participant identity and labelled as 'Healthcare Professionals Interviews', 'Managers

Interviews' and 'Service Users Interviews' respectively. A database was then compiled by uploading these files into ATLAS.ti computer-assisted qualitative data analysis software.

The coding methodology adopted in the present study was Structural Coding. Structural Coding serves as a fundamental methodological approach in qualitative research, particularly applicable for studies involving multiple participants and the employment of standardized or semi-structured data collection protocols, reflecting this study. This coding technique applies conceptual phrases that align with specific research inquiries to segments of data, thereby facilitating the organization and retrieval of relevant information (MacQueen et al., 2008). Structural Coding is a method for labelling and indexing, allowing researchers to effectively retrieve relevant data from a larger dataset (Namey et al., 2008).

This coding technique produced extensive text segments related to overarching themes, creating a basis for thorough analysis—both within and across selected topics (MacQueen et al., 2008). The method facilitated the preliminary classification of data, enabling further qualitative analysis.

Participant replies were reviewed multiple times during the coding process, as per stepwise process below, in line with the five phases approach as proposed by Yin (2011).

First through compiling, which involved collating all the participant transcripts into a managed dataset, so that it was cleaned, anonymized, and ready for the analysis. This gave the researcher an opportunity to get to know the detail and context of each response and develop

an early sense of the repetitive themes and emotional tenor of responses from the different stakeholder groups.

Second, during the disassembling phase, where initial codes were generated by systematically breaking down the narratives of participants into meaningful units. Open coding techniques were applied, with sensitivity to emergent concepts relating to stakeholder perceptions of co-design, structural barriers, emotional experiences, and relational dynamics. During coding, similar codes were grouped, with early categories created to explore how they might relate to each other, without losing the richness and nuance of the individual responses in transcripts which had been coded earlier in the process to explore whether any excerpts could be coded into codes which had been created at a later stage.

The third stage, reassembling, entailed clustering these categories into broader thematic patterns. This iterative stage involved several rounds of reviewing and refining so that the themes remained true to the participants lived experiences as well as beginning to form a coherent structure for further analysis.

The fourth step, interpreting, moved beyond simple categorisation towards constructing meaning from the data. Here, particular attention was paid to the relationships between codes, themes, and research questions, allowing the researcher to interpret how systemic, emotional, and epistemic barriers were perceived across different stakeholder groups. For example, managers often emphasise systematic and institutional constraints, whereas the focus of service users was more on emotional harm resulting from superficial participation.

Healthcare professionals held a complex middle space, often voicing systemic fatigue while still expressing commitment to co-design ideology.

Finally, in the concluding phase, the findings were consolidated into a narrative that critically reflected on the readiness of the Maltese mental health system for co-design. This study sought to capture both the explicit themes that were identified but also the underlying tensions, such as the dissonance between managerial rhetoric and frontline realities, the conditional nature of empowerment, and the emotional consequences of participatory marginalisation.

Throughout these five phases, an iterative, reflexive approach was maintained, ensuring that participant voices remained central to the analysis, and that emerging findings were not forced into pre-existing frameworks, but instead allowed to reveal the unique features and contextual insights of the Maltese setting,

3.6.1 Conclusion

The research conclusion will serve to bring the findings to a higher level of abstraction and understanding of the importance of the research outcomes

3.7 Ethical Considerations

The qualitative researcher has an ethical responsibility to safeguard the privacy of participants, prevent any harm to them, and uphold their right for self-determination and complete disclosure (Creswell & Poth, 2018). Given the study was conducted in different entities, the researcher had to undertake a long process to obtain the necessary permission for conducting the study.

Approval for the study was granted from the University of Malta Research Ethics Committee (UREC) (Appendix A). To comply with the protection of the rights of participants as per the research ethics, data collection commenced following the UREC and FREC approval.

3.7.1 Recruitment

Participants for the study were recruited from four separate entities. Even though there is an element of bias in including the company where I serve as Chief Executive Officer, recruitment was carried out through intermediaries, and this method was used for all the other entities to avoid the risk of coercion (Rebar et al., 2011).

No details of potential participants were given to the researcher prior to the interview phase, including those participants who might have refused to be part of the study.

3.7.2 Informed Consent

Prospective participants were provided with a detailed information letter outlining the study's aims, methods, and expectations. The aim of this letter was to provide the participants with an informed decision-making process to ensure they had self-determination and the right to withdraw at any time. Contact details of a qualified psychologist were also included in the information letter to help with any discomfort. The researcher made sure that participants had sufficient time to reflect on their involvement, so they were fully aware of the interview processes and data analysis methodology, to enable full transparency and participant awareness (Simons et. al, 2009).

Participants could avail themselves of the right of not answering questions or of withdrawing from the study at any point. In such instance, collected data was disposed of to stress ethical integrity. The methodology of the study is rigorous, ensuring participants felt comfortable and free from any distress. This approach is crucial in conducting research and promoting ethical conduct.

3.7.3 Confidentiality & Anonymity

Anonymity in qualitative studies is paramount, and measures need to be in place for safeguarding the identities of participants and to protect any direct linkage to the data (Rebar et al., 2011).

This study achieved this by systematically coding recordings and transcripts using pseudonyms throughout the research process. Personal data was stored separately from corresponding pseudonyms, and audio-recordings and transcripts were stored offline on a password-protected, encrypted computer. Any hard-copy material was placed in a locked cupboard. Audio-recorded data was deleted after transcription, as well as personal, with only anonymous data retained. Personal identifiable data will be deleted by September 2025.

3.7.4 Minimizing harm

Ethical research practices are founded on principles of human dignity, welfare, and integrity, emphasizing the obligation to prevent harm to participants (Israel, 2015). To safeguard participants from any harm, the researcher provided free psychological support. To be transparent and accessible, the details were provided in the information letter. Participants could avail themselves of the right of not answering questions or of withdrawing from the study at any point. In such instance, collected data was disposed of to stress ethical integrity. The methodology of the study is rigorous, ensuring participants felt comfortable and free from any distress. This approach is crucial in conducting research and promoting ethical conduct.

3.7.5 Reflexivity

Reflexivity is fundamental in qualitative research, particularly in case studies. It helps in gauging the way subjective elements interfere with the interpretation of participants' experiences and narratives built from interactions (Simons et al., 2009). Reflexivity helps

researchers identify subsets of their identity that may impact their engagement with the study, illustrates the researcher's decision-making process, and helps pinpoint biases for corrective steps during the research process. By recognising and countering biases, reflexivity ensures that the conclusions drawn do not place the researcher in a biased position (Simons et al., 2009). A reflexive journal was maintained throughout this research to acknowledge potential biases and ensure transparency in data interpretation.

3.8 Quality and Trustworthiness

To ensure quality and trustworthiness, this study adopted a rigorous methodological approach integrating key frameworks from Guba and Lincoln (1985), Lincoln (1995), and Yardley (2000). By employing credibility, dependability, authenticity, commitment and rigour, transparency and coherence, and impact and quality, the study maintains a high standard of research integrity and reliability.

3.8.1 Credibility

Credibility was ensured through member checking, where participants reviewed and verified their interview transcripts (Saldaña, 2009). This ensured that the terms used, meanings, and rationales of the participants were preserved and that the contents reflect their views. Participants were given the opportunity to edit the information as they deemed fit. This, as proposed by Yin (2011) was done to ensure the validity of the data collected and secure further validity for the study. Referential adequacy was used, which allowed revisiting data

sources through audio recordings; as well as triangulation, where multiple perspectives and multiple data sources (sites) were cross validated (Yin, 2011).

Transcripts were not returned to service users due to confidentiality concerns as well as time constraints. Most service users do not have access to emails, so the only way to give them the transcripts was by either passing them on the professionals, compromising confidentiality, or else personally re-visiting all service users, which was not possible due to time constraints. Another reason for not going through this process with service users was to avoid potential distress from the re-collection of the narratives, thus prioritizing participant well-being and study integrity (Birt et al., 2016).

3.8.2 Dependability

Dependability was reinforced by maintaining an audit trail, documenting all research steps from data collection to analysis, ensuring methodological transparency. Triangulation and external review through debriefing with a supervisor provided further validation. Reflexivity was practiced through a reflective journal, minimising bias and enhancing the reliability of findings.

3.8.3 Authenticity

Authenticity was achieved by ensuring diverse stakeholder representation, incorporating perspectives from service users making use of different service and, mental health professionals and managers coming from different professions. This is also in line with the

emphasis made by Lincoln's (1995) on representing different point of views to obtain a holistic understanding.

3.8.4 Commitment and Rigor

Commitment and rigor were demonstrated through engagement with participants, detailed record-keeping of all aspects of the research process, and the completion of a comprehensive analysis that was respectful of participants' stories (Yin, 2014). Dependability was ensured through replicability. The author describes how participants were selected, how interviews were structured and conducted, and how data was analysed, ensuring future researchers can reproduce its findings.

3.8.5 Transparency

Transparency and coherence were demonstrated through comprehensive methodological documentation, explicitly denoting the research design, participant selection, data collection, and analysis. Multiple drafts and systematic reporting ensured consistency between research questions, methodology, and findings.

3.8.6 Impact and Quality

Impact and quality were emphasised by addressing a critical gap in mental health service planning, particularly regarding stakeholders' perspectives on co-design prior to its

introduction. The findings of this study provide practical and theoretical contributions by informing policy, tailoring service implementation strategies, and enabling the voices of healthcare professionals and service to influence future mental health interventions.

This study aligns with the participatory ethos of co-design, whereby rigorous methodological procedures are interwoven with ethical and transformative considerations, enhancing its validity, reliability, and potential impact within the Maltese mental health system.

3.9 Conclusion

This chapter outlines the research design, theoretical framework, philosophical underpinning, as well as the research methods that guide the present study. Based on an interpretivist paradigm, implanted within established theories, and supported with rigorous research methods, the study aims to explore stakeholders' perspectives of co-design in mental health service planning in Malta, and consequently to identify ways to mitigate the challenges, and foster a more contributory and useful mental health service design.

CHAPTER 4: DATA ANALYSIS

4.1 Introduction

This chapter outlines the key findings emerging from the qualitative data collected during the interviews with service users, healthcare care professionals and managers. It seeks to provide an understanding of co-design within mental health services planning, by featuring the perspectives of the stakeholders and understanding the perceived benefits, involvement motivations, and the barriers that may hinder its implementation. This chapter aims to contribute to the ongoing discussions on mental health practices and policies and will provide a platform for the discussion of broader theoretical and practical implications in the next chapter.

4.2 Data Set

A total of 23 participants took part in the study: 16 professionals and 7 service users.

The professionals were between 23 and 52 years of age, which included 4 healthcare professionals in managerial roles, 2 females and 2 males, and 8 healthcare professionals in roles of social work, occupational therapy, nursing and care, 1 male and 7 females. The service users were between 23 and 77 years of age: 5 males and 6 females.

Professionals' years of experience in the mental health sector ranged from 4 to 26 years

Service users' use of mental health services ranged from 2 to 42 years.

Different sectors were represented: 3 professionals and 3 service users from the national mental health hospital; 3 professionals and 2 service users from an NGO; 3 professionals and 3 service users from a private community residential home; and 3 professionals and 3 service users from a private psycho-geriatric residential home, thus covering public, non-profit, and private organisations.

4.3 Data Findings

This chapter elucidates the interpretation of data gathered from three primary cohorts: health care professionals and managers within the mental health sector, as well as service users of these services.

During the interviews, participants in this study were invited to share their perspectives on the implementation of co-design in mental health services, with a focus on their inclusion, contributions, and the potential challenges and benefits of this approach.

Although most participants were Maltese-speaking, they occasionally switched to English during the interviews. As a result, the quotes presented in this study reflect this natural code-switching, with responses in Maltese, which were then translated into English, and others in English. Direct quotes are presented as spoken to preserve authenticity and meaning. The quotes for English-speaking participants were presented in their original language only.

Following Yin's (2014) case study approach, and as detailed in Chapter 3, a stratified analytical framework was implemented to organise and analyse the qualitative data. Initial codes were generated inductively from the data then organised into sub-categories to show emerging patterns. These were then grouped into wider categories to support the explanations' structuring. Finally, overarching themes were developed to generate meaningful insights across participants' responses and effectively answer the research questions. This process enabled the interpretation and comparison of perspectives grounded in data. These themes enabled a structured and coherent presentation of the results, whilst highlighting the key issues raised by participants.

The following section presents a detailed analysis of the key themes that emerged from the data. To offer clarity and structure, each theme is broken down into sub-sections that represent the specific categories through which the themes were derived. These categories served to organise the underlying codes and highlight the nuanced dimensions within each thematic area. This structure allows for a deeper exploration of the data while maintaining coherence and analytical depth.

Table 4. 1 - Thematic coding structure

Theme	Category	Sub-categories
1. Valuing Lived Experiences: A Foundation with Fractures	Valuing Lived Experience and Knowledge	<ul style="list-style-type: none"> - Tacit Knowledge and Lived Experience. - Self-effacement and Feeling Undervalued. - Professionals' Inability to Understand Service Users.
	Inclusive and Meaningful Engagement	<ul style="list-style-type: none"> - The Value Added of Diverse Perspectives for a Person-centred Approach. - Superficial Inclusion and the Risk of Tokenism.
2. Trust and Psychological Safety: The Emotional Prerequisites	Emotional and Psychological Impact	<ul style="list-style-type: none"> - Fear of Judgement and Stigma.
	Trust, Safety and Relationship Building	<ul style="list-style-type: none"> - The Importance of Building Trust. - Facilitating the Process.
3. Structural and Logistical Barriers: The Weight of the System	Structural and Systemic Barriers	<ul style="list-style-type: none"> - The Struggle with Resource Shortages. - Stability over Transformation. - Complex Process - Challenges in Participants' Selection and Representation.
	Barriers to Service Users Participation	<ul style="list-style-type: none"> - The Risk of Re-Traumatisation. - Lack of Interest in Participation. - Varied Service Users' Capacities. - Service Users' Behaviours.
4. Relational Barriers: Communication Breakdowns and Conflicting Visions	Barriers to Dialogue and Share Visions	<ul style="list-style-type: none"> - Communication and Cultural Barriers. - Defensiveness and Lack of Shared Vision.
	Professional Relational Barriers	<ul style="list-style-type: none"> - The Reality of Power Dynamics. - The Strength of the Medical Model - Adopting a Paternalistic Approach
5. Motivational Drivers and Perceived Impact of Co-Design	Motivation and Willingness to Engage	<ul style="list-style-type: none"> - Professional Growth. - Opportunity to Help Others and Mutual Benefits.
	Benefits of Co-Design	<ul style="list-style-type: none"> - Involvement of Service Users and Person-Centred Outcomes. - Empowerment and Hope. - Benefits for all Stakeholders. - Improving Quality of Life. - Professional Satisfaction. - Cost and Service Effectiveness and Producing Better Outcomes. - Sharing a Common Goal.

4.4 Theme 1. Valuing Lived Experiences: A Foundation with Fractures

Through coding, two categories were identified and consolidated under this overarching theme: Valuing Lived Experiences and Knowledge; and Inclusive and Meaningful Engagement.

4.4.1 Valuing Lived Experiences and Knowledge

Statements coded under this category indicated that both healthcare professionals and service users believe that they could give an important contribution to co-designing mental health services and, in most cases, would be willing to participate.

Tacit knowledge and Lived Experience

Healthcare professionals stated that their tacit knowledge equips them with a deep understanding of the practical challenges and requirements of the service and its users that may not be readily visible.

Professional 3 said that her continuous work with the service users and knowledge of their needs would be very important in a co-design process *“Having professionals who spend a lot of time with the service users helps such process as they will know better than others”*

Professional 8 agrees with this and says: *“Healthcare professionals should be heavily involved in designing the mental health services. This is because we are working one-to-one with the client on a regular basis”*.

Professional 6 views her contribution, together with that of other similar professionals, as valuable as they can be *“in a better position to advocate for the people who utilise mental health services from the current practice...”*.

Professional 2 says that *“I believe I have some ideas that I can also impart to a team for the betterment of the service users...I think they would hear me out and maybe try to impart my ideas”*.

Most of the service users who participated in the study consider themselves as experts-by-experience through the knowledge they acquired on their condition by living daily the challenges it brings along with it.

Service User 1 was confident that she would be able to give a tangible contribution had she to contribute to a co-design process:

“B’li għext jien naħseb inkun naf u nista’ nagħti kontribut. Biex tifhem lil dak li jkun, għax jien għaddejt minnhom – jien naħseb li kapaçi nagħti kontribut. Naf xi jfisser tħossok waħdek mingħajr support u xi jfisser tieħu ħsieb ta’ xi ħadd ieħor”.

“Through my lived experiences, I would know, and I would be able to contribute. To understand someone, because you have lived it as well – I believe I am able to give a contribution. I know what it feels like to live with a mental health condition and having no one to support you and I know what it means to support and live with someone who has a mental health condition. ”

Service User 3 also agrees, and she says:

“Milli għaddejt minnu nħossni esperta tal-ħajja, minn mindu kont tifla sa lllum, għandi esperjenza kbira”.

“From what I have gone through, yes, I do feel an expert of life, as I have gone through a lot from a very young age till today, my experience is vast”

Service User 11 said that his illness made him an expert on his condition, and also helped him during his life, in navigating his own condition:

“I do consider myself as an expert by experience. If you are asking what is exactly going on, I do yes. From my experiences it teaches me, and I am forever trying to find a code or a way that I can click outside of OCD – I try but it’s totally in my mind all the time, it doesn’t stop. I don’t know how to solve it, but I know the dynamics”.

When Service User 4 was asked by the researcher whether he thinks that services could be improved if we listen to service users, he replied that his contribution would be valuable:

“Depends on the subject you are asking. Because not everyone has the same things. You have to ask the person about the subject, as in what they want, cause not everyone shares the same thing. Depends on the person, because everyone is different in their own way”.

Self-effacement and Feeling Undervalued

Even though health care professionals and service users who participated in this study would be willing to be included in co-design, they feel that their ideas are, or would be, undervalued which leads to feelings of self-effacement, frustration and fear of not being considered.

Professional 5 said:

“Xi kultant huma disempowering l-affarijiet li jiġru fil-pajjiż... mhux għax int ħa taħdem għal xi ħaġa bħala social worker neċessarjament ħa ġġibha, ġieli you are not allowed to talk fuq ċertu problemi li forsi taffaccja fix-xogħol jew tikkritika... qisu it’s not so allowed. Trid toqgħod attent kif titkellem...”

“Sometimes things that happen in this country feel disempowering. As a social worker you can strive towards achieving a goal, but despite all the hard work you put into it, results remain unattainable. Sometimes it seems like you aren’t even allowed to talk about the problems you encounter at work. Constructive criticism itself seems to be frowned upon...”

Professional 4 mentioned that even though professionals are involved, many times their opinions are not given value: *“While such professionals are invited to these discussions, they are often less involved in decision-making and are rarely informed about the outcomes of projects”*.

Manager 4 said that this creates frustration amongst professionals, *“...ending up into decisions not taken at the detriment of the person using the service and the frustration on other professionals who would wish for the best for the service users and that things happen”*.

Service User 9 was confident with the idea of participating when asked by the researcher whether she would feel able to contribute to the design of the service, but when asked whether she thought that her ideas would be given value during a co-design process she said, in relation to a suggestion she had recently made:

“Jien tkellimt quddiemhom, ma tawh xejn valur. Ma għamlu xejn minn dak in-nhar ’l hawn, xorta bqajna l-istess”.

“I did speak up, but they didn’t give any value to what I said at all. Nothing was done since then and things remained the same”.

When the researcher further asked whether this meant that she believed that professionals would not give value to her opinion, she categorically answered: *“Ma jagħtux każ”* (“They won’t consider me”). She further went on in saying: *“Imma għalxiex iriduni?”* (“But why would they want me?”) and that:

“Jien inutli li ħa mmur nieħu sehem. Għax ma jagħtux każi”.

“It’s useless that I participate. They won’t bother to hear what I have to say”

stating that she would participate but was very sure she would not be considered.

Service User 7 also believes that her opinion would not be considered:

“Tajthom pariri biex jibagħtu għalija għall-servizz ieħor imma ma bagħtux imma”.

“I did advice that I should be moved to another service, but they haven’t got back to me yet”.

This sentiment was corroborated by Professional 5 who said:

“Jiena naħdem f’settings differenti. Fejn hemm a health setting, fejn hemm qisu dak it-team work, u a healthy environment, inħoss li iva, il-persuna għandha tingħata l-ispazju, il-platfomm, whatever. Imma mbagħad hemm ċertu sistemi li huma, li ma jaħdmux tajjeb, u hemmhekk żgur, anqas biss tgħaddilhom minn moħħhom li jkun hemm din l-idea ta’ a person expert at the same level as other people... anke persuni professjonisti oħra jibgħatu”.

“I work in different settings, in some settings where there already is a healthy teamwork in place, the expert by experience would be given the space to contribute to the platform. However, in other settings which already barely function well enough to promote healthy teamwork between different professionals, this would be a problem. They would not acknowledge the expertise of an expert by experience, they already do not acknowledge the expertise of other professionals.”

From her end, Professional 6 points out that, in her opinion, there is a lack of credibility on service users’ opinion:

“Sfortunatament forsi l-kwalifiki għandhom aktar weight minn esperjenza. So isu meta se titlob proposal higher up, pereżempju lil xi Ministru, għalhekk hu tajjeb li jkollok

“Unfortunately, many times qualifications seem to have much more weight than lived experiences. If you are going to propose something to someone on a high level, like at Ministry level, it’s

daqxejn minn kulhadd. Għax ikollok l-esperjenza plus l-kwalifiki ta' nies oħrajn”.

good to have a mix of stakeholders – to have both the academic part and the life expertise part”.

Service User 1 would be happy to be included in such a process, but she still said she would need encouragement.

“Għax noqgħod ngħid jien ma nafx, inwaqqa’ s-self-esteem tiegħi.”.

“As I would think, I am not good enough to participate, due to my low self-esteem”.

Service User 8 was sure that her inclusion in a co-design process would not be valued by professionals and stated:

“Eee... fuq xiex? Le, nagħti ideat imma huma jagħtu l-pilloli”.

“What...on what?! I would give ideas, but they give treatment.”

Service User 3 does not feel confident in participating:

“Naħseb li m’iniex kapaċi, naqta’ qalbi “.

“I don’t think I would be able to, I would feel helpless”.

The services users’ sentiment is echoed by Manager 3 and Professional 6. Manager 3 says that:

“...Anke fejn jidhol service user, jista’ jkun forsi jhossuhom intimidati għax iħossuhom ma jifhmux biżżejjed”.

“...service users could also feel intimidated as they would feel not good enough to contribute”.

Professional 6 say that:

“Minn naħa ta’ service user, forsi iħoss għax dak li jkun jaħseb li peress li m’għandux ċertu kwalifiki l-esperjenza mhix biżżejjed. Jien din ma ċertu nies inħossa – jgħiduli għax int tifhem, għax nhalli f’idejk – le, mhux tħalli f’idi. As in it’s a collaboration, mhux jien se ngħidlek x’trid tagħmel. So isu mil-lat ta’ ċertu nies iħossuhom żgħar fejn nies

“From a service user perspective, they might think they are not up to be part of such fora, since they are not academically qualified, and their experience would not suffice. I do feel this with certain individuals – they tell me that I am the expert, leaving the decision up to me, to which I reply that the decision should not be up to me, but

oħra peress li għandhom biss l-esperjenza u mhux il-kwalifiki. Jew ta'hom ikunu anqas minn ta' ħaddieħor".

it should be made in collaboration, together, and not I tell you what to do. So, to a certain extent, there are individuals that feel small compared to others, since they only have their lived experiences to share and no qualifications to show. They might also feel that what they experienced is less important than what others experienced".

Even though Service User 4 believes in his potential to contribute, he said he was unsure of his participation: *"No, there is still a lot for me to learn. Because I know our universe is vast...and for me to say I am an expert just because I went through hardships that would be a lie because the universe is so vast and amazing that there is probably someone even better than me".`*

When asked by the researcher whether his ideas would be listened to by professionals, Service User 10 said that they would, but:

"...trid tara mbaġħad jekk jiġu implimentati l-ideat jew le".

"...one needs to see then whether my ideas would be implemented or not".

Professionals' Inability to Understand Service Users

Service users participating in this study stated that there is a general lack of understanding as some professionals are unable to understand what a service user has gone through, both because they might be unwilling and being unable to do so. Some service users also expressed discomfort in sharing their experiences and ideas should they participate in a co-design process due to this

When asked whether she thinks that her ideas would be considered by professionals, Service

User 1 said:

“Ma narax għalfejn le... iva, kultant mhux dejjem jistgħu jifhmuk”.

“I don’t see why not... even though sometimes they might not be able to fully understand you”.

She went further to say,

“...skont il-professionista, għax mhux kulhadd xorta”.

“...but maybe it depends on the person who is listening to you as they are not all the same”.

Service User 3 also said that professionals lack understanding:

“Ma naħsibx li jagħtu każ, għax naħseb hadd ma jemmini. Għax trid tgħaddi minnhom l-affarijiet. Jien nista’ nitkellem għax fhimthom, imma haddieħor ma nafx jistax jifhem, ma nafx jgħaddix il-messaġġ”.

“Don’t really think that my ideas would be considered as they won’t believe what I have gone through. One must go through the experiences to really understand. I can talk about them as I understood through my life experience, but other persons cannot...”.

She went further on saying,

“Imma jekk jien niġi nitkellem ma’ min m’għaddiex minnhom, ma jifhimnix”.

“Had I to talk to other persons who did not go through my life experiences, they won’t understand.”

Service User 8 was sure that professionals would not give weight to her ideas, due to a lack of understanding, and added that:

“...imma eżatt ġo l-istonku ta’ dak li jkun, ġo moħħ ma jistgħux huma jhossu għaliex x’inqu jkun qed iħoss il-bniedem”.

“...professionals cannot understand the feeling in your stomach, what is going on in your mind, they cannot feel that...they cannot feel what the person is going through”.

She went on by saying,

“Ma nafx jekk għaddewx minna jew le, imma jien għaddej minna, naf xi jfisser.”

“I don’t know whether they went through it or not but I, that did go

Imma huma jgħiduli 'orrajt, mela hu l-pilloli hekk għax qegħdin hekk.' Imma jien mhux dik inkun irrid, jien inkun irrid dak il-kliem ta' sapport hu, għal dik iċ-ċirkostanza, f'himt? Mhux billi jagħtu sempliciment il-pilloli".

through it, know exactly what it feels like, but they would tell me, ok take the medications but that would not be what I need. I would need words of support and comfort for that circumstance, you understand me. It's not only about giving pills".

Professional 3 emphasized the importance of professionals' understanding the service users:

"It is important that professionals embrace the need of understanding the service users. Every individual is different, but we need to understand what they need, how they think and why they are thinking so".

4.4.2 Inclusive and Meaningful Engagement

The Value Added of Diverse Perspectives for a Person-centred Approach

Manager 1 believes that having service users contribute to a service's co-design would ensure a tailor-made approach, as you would be getting first-hand information, leading to a person-centred approach and added value.

Whilst talking about the service users, Manager 1 said that their opinions are extremely important:

"...bla dubju, għax daqs kemm jaf hu x'għandu b'zonn, żgur ma nafx jien u l-ebda professjonist ieħor.

"...there is no doubt about that. Who better than himself would know what he really needs? Certainly not me and neither any other professional.

Manager 4 further stated that *"...having different opinions is beneficial for a better service and it can also lead to tailor-made ones".* She also believes that service users might have ideas

which professionals would never think of, and such *diverse perspectives* would be of great benefit in a co-design process:

“Services should be created based on their ideas. From the professional’s end, we should consider and put forward our perspectives, but the service users are at the receiving end. Some of the ideas service users come up with we might not even think about them, and we need to remember that, at the end of the day, the service is meant for them not us”, and that their inclusion leads to better outcomes: “Listening to different ideas help in producing better results”.

Professional 6 emphasised the importance of service users’ inclusion in co-design.

“Co-design irid jibda mill-bidu nett sew għax fl-aħħar mill-aħħar is-servizz se jkun qed jintuża minn dawn in-nies infushom. So għalhekk importanti — huma jafu x’esperjenzaw, x’għandhom bżonn, x’m’għandhomx bżonn.”

Co-design is involving the service users from the start of the design because, ultimately, they are the ones who would be using the service. That’s why their input is very important because they are the ones who are going through their experiences, and they are the ones who know what they need or what they don’t need”.

From his experience, Professional 4 said:

“...in my experience, Meta kelli l-opportunità li l-experts-by-experience ikunu involuti fid-disinn ta’ servizz jew ta’ policy, il-possibbiltà li jkun successful naraha li tkun ikbar jien. That’s why I understand the importance of it.”

“...in my experience, when we actually did get a chance to involve these “experts by experience” in the design of a service or policy, I felt that the potential for a successful implementation was greater, and that is why I can understand the importance of it”.

Healthcare professionals stated that they also view their inclusion in the design of mental health services as an enhancement to the creation of more effective and person-centred services.

Professional 6 said that by participating in a co-design process:

“...tista’ timxi iktar b’dak li għandha bżonn il-persuna, b’dak li l-persuna tixtieq bħall-ispeċi. U dik toghġobni ħafna”.

“You can work towards the service users’ needs and wishes, which is something I strongly cherish”.

Professional 3 states that: *“Every individual is different, but we need to understand what they need, how they think and why they are thinking so”* which is why she views her inclusion as well as that of other professionals as very important as *“We are not the same, we all think in different ways, and we all have something to share”.*

Professional 8 said that having healthcare professionals included in the design of services is important as:

“Bħala professionals, kulhadd jaf li dak li jrid il-klijent huwa l-aktar ħaġa importanti u our job is to meet the needs of the client”.

“Professionals know that the most important thing is to meet client’s wishes and that our job is to meet their needs”.

Professional 3 said that her continuous work with the service users and knowledge of their needs would be very important in a co-design process *“Everyone who can contribute should be involved and, yes, I would like to be involved, because I know the service users and I know also how to speak with them as they accept me.*

Professional 8 agrees with this and says: *“Healthcare professionals should be heavily involved in designing the mental health services. This is because we are working one-to-one with the client on a regular basis”.*

Professional 2 said that even though *“through the process I know, identifying the challenges and trying to explore in depth could also be a barrier, but I still see my participation and feedback in such fora as important”.*

Superficial Inclusion and the Risk of Tokenism

Professionals participating in this study mentioned superficial inclusion, or tokenism as an element they perceive in hindering a successful co-design implementation, whereby an appearance is created that the process is being done but without genuinely valuing the service users’ contributions or addressing systemic issues.

Professional 5 said that, even though the seed has been sowed, there is still a long way to go to avoid tokenism:

“Naħseb li bħala kuncett, naħseb li qiegħda tidħol, li qegħdin ninvolvu l-persuni, imma għandha forsi daqxejn superficiali fiha din il-ħaġa. Jew għadha ’l bogħod — qisna qed... we are not doing it, it is not engrained in our beliefs, inħoss. Qisu, when it’s happening, we are going out of our way to do this and so we have to be grateful. Qisu, our attitudes are not there yet.”

“I think the concept is being introduced slowly, and individuals are being involved, but it is all very superficial. It is like the whole concept is not engrained into our beliefs, and it will take a while for it to be implemented properly. It seems that people who are involved are not doing it because it is the way that things are meant to be done but expect others to be grateful for their involvement as they are going out of their way to be involved. It seems as though our attitudes aren’t there yet”.

Professional 6 also pointed out the high possibility of such an approach being tokenistic:

"...mhux l-ewwel il-policy makers ifasslu s-servizz, imbagħad jibda s-servizz, imbagħad indaħħlu s-service users għal feedback. That is not co-design".

"It's useless to have the policy makers first designing the service and then asking the service users for feedback – that is not co-design".

"Sfortunatament, din tista' tintuza bħala tokenism. Ngħidu li għamilna l-co-design... u ma jkun co-design xejn."

"Unfortunately, this process can be used as tokenism. We say that we have done co-design, and it wouldn't be co-design at all".

4.5 Theme 2. Trust and Psychological Safety: The Emotional Prerequisites

Through coding, two categories were identified and consolidated under this overarching theme: Emotional and Psychological Impact; and Trust, Safety and Relationship Building.

4.5.1 Emotional and Psychological Impact

The codes within this category explain important elements that stakeholders believe would impact the participation of service users in co-design.

Statements coded under this category indicated that some service users participating in this study do not feel safe in participating in co-design initiatives due to a lack of trust and fear of judgement, as well as stigma.

Fear of Judgement and Stigma

Service User 3 said that she would feel uncomfortable sharing her lived experience if she does not trust a person.

“Qed niftaħ qalbi miegħek għax naf li m’intix sejra barra tpaċpaċ... però m’iniex lesta li jien ngħaddi lil ħaddieħor. ”.

“I am opening up to you as I know that you won’t go back and tell my story to the four winds...but I am not ready to pass on this to others”.

She further says:

“In-nies jiġġudikaw... jien naħseb għan-nies tibqa’ t-tabella, mhux għalik”.

“People are judgemental...I believe that for others it is a label, and it remains so, even if it’s not the case for yourself”.

Service User 2 mentioned:

“Anzi, jekk ngħidhom, jgħidu bija... in-nies jiġġudikaw”.

“I believe that had I to share they would judge me. People are judgemental”.

Service User 10 attributed this discomfort to sharing to stigma:

“Jien nemmen li l-mard mentali jixbah lil mard li jittieħed – kulħadd jibza’ jersaq lejn in-nies li għandhom”.

“I believe that mental health diagnosis is seen by most as infectious diseases – everyone is afraid to go near them”.

He feels intimidated as he might not be psychologically ready for such a process said:

“Trid tkun b’saħħtek psikologikament għalihom biex ma tħallix kemm il-persuni ta’ madwarek jeffettwawk kif ukoll l-istejjer li tkun qed tisma’. Trid tkun kapaċi wkoll ma titgħabbix bil-problemi ta’ ħaddieħor”.

“You would need to be psychologically strong for such a process not to let anyone affect me both with their attitudes as well as the stories I hear. One needs to be able not to take on the problems of others”.

The sentiment shared by the service users was also reflective in the perspectives of

Professional 8, who said that:

“Tidhol f’kamra ta’ nies li ma tafx, tħossok uncomfortable u intimidating, hux? Għax ejja ngħidu jien il-client u ħa mmur ġo dan il-grupp... are they judging me? – it is anxiety provoking”.

“Being in a room with persons you don’t know would make some feel uncomfortable and intimidated for sure. It could also provoke anxiety, as service user might feel judged”.

Manager 2 agrees with Professional 8 and states the importance of providing a comfortable set-up for service users for them not to feel intimidated: *“If the service users are in a meeting with the psychiatrist, who is typically dressed in formal wear, they will feel intimidated and scared to voice their opinion...”.*

Professional 7 also believes that:

“...il-persuna li għandha bżonn is-servizz, kultant meta ssemmilhom tabib jew psikjatra jingibdu lura, però meta ssemmilhom carer ikunu aktar komdi.”

“...service user might be more comfortable in sharing in a forum where there is not only just the psychiatrist present, which at times might feel intimidating, but also carers with who service users can relate more with and feel more comfortable around”.

Professional 4 stated that:

“Naħseb illi, in terms of stigma, dik hi l-iktar li żżommna milli jkollna l-mental health inkorporat mal-physical health”.

I believe that stigma is possibly one of the things that keeps mental health emarginated from other conditions”.

Professional 1 goes further into details by saying that:

“Hawn minnhom bl-istigma tas-saħħa mentali. Eżempju... jekk mentally għandi problema, ma tiġix emmnuta direttament... u hekk qisna m’għandhomx 100 fil-mija fiduċja fihom”.

“I believe that stigma also exists within the professionals themselves, and they don’t trust services users’ opinion 100%”.

When asked by the researcher why she thinks that the co-design approach has not yet been implemented in Malta, Manager 2 said that: *“I think it is mostly the stigma, as soon as you mention mental health issues, people tend to take a step back”*.

This corroborates what service users mentioned as a reason for not being keen to participate.

4.5.2 Trust, Safety and Relationship Building

Participants of this study said that meaningful participation can only become effective if due importance is given to relationship building and if the co-design process implements a structured approach with a support network available to facilitate the process.

The Importance of Building Trust

Manager 2 said that service users need to be comfortable in these situations so building trust is very important: *“You need to understand that the service user will not trust you immediately it is important to build a bond with the service user...so the person starts trusting you and therefore providing you with fruitful answers”*.

Manager 1 is also of this opinion:

“Jekk ikun hemm trust, jekk jirnexxilhom jibnu dak il-bond, kulhadd jista’ jkun kapaċi”.

“If they manage to build a trust relationship with the people in the meeting, then anyone can contribute”.

He went on to say,

“Meta jkun hemm dik ir-relazzjoni ta’ fiduċja, huma jifhmu jekk tgħidilhom xi haġa kontra l-ħsieb tagħhom, imma jekk imur xi hadd li huma ma jafux, ħa jirritaljaw.”

“...residents accept opinion which are different than theirs from people they trust, but don’t do so when it is coming from people they do not yet know”

Professional 1 also feels that service users may experience an element of lack of trust:

“...għax ikunu mbezzgħin nemmen — qisna nkunu nafu jekk hawnx se ngħidu xi haġa. Ġieli jkunu għaddew minnha fil-passat, jiġifieri jekk se tgħid xi haġa mhux se tiġi emmnuta, allura fil-verità aħjar ma tgħidx xejn. U tipo mhux se jkollu dik il-wegħha li għidt xi haġa u ma ġejtx emmnuta”.

“...there would still be an element of fear I believe, fear that they might say something, especially in relation to a past lived experience, and they wouldn’t be believed and that would create additional pain and suffering to them”.

This is also corroborated by Service User 10 also emphasised the importance of trust to participate:

“...il-fatt li hemm persuna li tista’ tafda hi l-isbaħ haġa u lili għenitni ħafna....”

“...the fact that there is a person that you can trust is the most beautiful thing you can have, and it helped me a lot.

“Sakemm nikseb il-fiduċja lejn il-persuna, ma nkunx komdu — wara, iva.”

“Until I earn the trust towards the person, I am not comfortable, once I do yes”.

Facilitating the Process

Manager 2 ties the importance of a support network to a structured approach for effectiveness:

“The meeting and interactions need to be adapted according to the needs of the service users to make sure they are comfortable with the approach being taken. If the service user prefers a

small group, it would be a mistake to hold a large group meeting and expect the service user to participate". With reference to the importance of having a support network: "...if the social worker or OT is involved it might be a bit different, as they generally have a stronger relationship with the patients, and the patients tend to be more open with them".

Manager 3 mentions the importance of facilitation and says:

"Naħseb li ovvjament dak li jkun, l-ewwelnett li qabel forsi wieħed, xi ħadd ipogġi bilqiegħda mal-individwu u jispjegalu x'se jiġri u x'inhu l-kuntest. Li jiġi akkumpanjat jew minn xi relative jew minn xi ħadd li jista' jispjegalu x'inhu għaddej. Jekk persuna ssibha diffiċli qisu biex tidhol fil-konversazzjoni, ħa tkun diffiċli — imma hemm individwu u hemm individwu. Imma fil-każ tagħna dejjem jista' jkun hemm ir-relatives tas-service users".

"I think obviously one would sit down with the individual and explain to him what is going to happen and what the context is. Being accompanied either by a relative or by someone who can explain to him what is going on could also help. If a person finds it difficult to engage in the conversation, it will be difficult, but not all service users are the same. However, having said that, in such cases, relatives may speak on behalf of patients".

Professional 8 also mentioned that successful participation requires:

"...irid ikun element ta' preparation qabel dawn il-meetings... li kulħadd ikun jaf l-history tal-klijent; minn xiex ibati, u you prepare x'ha tgħidlu l-client. So, irid ikun element ta' preparation qabel dawn il-meetings.

"...preparations must be made beforehand...all professionals involved would have a brief of the service user, so there would be an element of knowledge and understanding in how to lead the meetings.

This would require a support network, like for example what Professional 2 mentions the needs for service users' participation, saying that: *"I think they also need that help, like explaining, like a facilitator".*

Professional 8 also mentioned the importance of being prepared to offer any kind of support:

"..so we have to prepare biex tara kif ħa tikkalma l-klijent jekk fil-każ li ħa jirrabja jew jitlef il-kontroll".

"..those involved need to be made aware and taught or have someone to support on how to de-escalate the service user if such instance occurs".

Service User 10 stressed the importance that meaningful participation needs a good structure:

"Qabel il-laqgħat, iridu wkoll jiġu spjegati r-regoli ta' kif dan il-proċess ħa jimxi sabiex wieħed ikun jista' jifhem".

"Before the meetings, the rule of the process needs to be explained so those how are participating would be briefed and aware of how this process will be conducted and understand accordingly".

Service User 8 confirmed the need for support:

"...jien inkun irrid dak il-kliem ta' support hu, għal dik iċ-ċirkostanza, fhimt?"

"I would need words of support and comfort for that circumstance, you understand me?"

When further asked by the researcher what help would she need to be able to participate, Service User 8 replied:

"Psikologa, terapista hu, xi ħadd hekk. X'għandi nagħmel".

"A psychologist or a therapist, someone like that. To guide me how to go about it".

Manager 4 also agrees and says that: *"...support is very important for their involvement and using a peer to help not a professional even more so, it's more valuable".*

4.6 Theme 3. Structural and Logistical Barriers: The Weight of the System

The following two categories were organised to reflect a coherence overarching theme: Structural and Systemic Barriers; and Barriers to Service Users' Participation.

4.6.1 Structural and Systemic Barriers

This category captures a number of factors that participants in this study described as potential barriers to participation in a co-design process.

The Struggle with Resource Shortages

Resource shortages, being human, financial and time related, further challenge meaningful engagement. Most of the professionals participating in this study believe resource shortages to be one of the main hinderances in the implementation of a co-design process.

Manager 4 when says that: *“The biggest challenge we face is human resources. This challenge is a common challenge, in all sectors”*. Manager 2 said that: *“There is also a problem with both quantity and quality of the professionals, as there aren't enough nurses and doctors who are specialised in the area”*.

Professional 4 also agrees that:

“Problema oħra hi r-rizorsi... huma limitat ħafna ...”.

“Another problem is resources...they are very limited...”

As does Professional 8, saying that “...to get successful outcomes, more human resources are required”.

Such shortages create problematic for professional, like those mentioned by Professional 5:

“Ovvjament inħossni naħdem lejl u nhar, so xi kultant inħoss li kieku kelli role wieħed biss, ovvjament kont nagħmlu b'aktar kwalità... però sfortunatament bħala social workers m'għandniex ...”

“I feel like I have too much on my plate and that if I had only one role, I could dedicate more time to it and give more quality...but unfortunately, we lack social workers...”

She also mentions the risk of disengagement due to these shortages:

“...l-aktar ħaġa li isu challenging ukoll u frustranti għalija hi li jien, flimkien ma' aġenziji oħrajn, isni xi kultant inħoss that we don't even acknowledge this together, jiġifieri we don't even say it is a problem. We say it's not my problem anymore rather than coming together to try and see how to address gaps”.

“...the most challenging and frustrating thing is that I, along with other agencies, feel that sometimes we don't even acknowledge the problem. We say it's not my problem anymore rather than coming together to try and see how to address our gaps”.

Professional 3 also acknowledged the time constraints of working in this sector saying that:

“...we don't have time to do new things... but believes that:” ... somehow, we can always make time, it's just a matter of willpower”.

Professional 1 perceives this process as time consuming:

“Naħseb għax jieħu l-ħin biex toħolqu? Sakemm tiddiskutu, sakemm tiltaqgħu, sakemm tigu tipo f'liema linja se tagħmlu, sakemm tiddeċidu u tagħzlu

I think it would take a lot of time for this to be implemented, right? Meeting up, discussing, understand the line of action to be taken, deciding and choosing,

għax dan min jgħid hekk u min jgħid hekk għax ma naħsibx li tkun persuna waħda. U sakemm taħqdu u tagħzlu liema se tagħmlu, naħseb li tieħu l-ħin”.

together with having different persons with different and sometimes differing views, looks like very time consuming to me. Even until you secure its startup, meaning until you find the persons who will participate, communicating with them, matching dates and times, would be very time consuming”.

Professional 8 is quite sure that implementing a co-design process would be very time consuming:

“naħseb time consuming imma. Issir taf il-klijent qabel ma tibda tiltaqa”.

“...is very time consuming, though. The team needs to get to know the service users before the process starts as this process takes time”.

Manager 3 mentioned how challenging participating in a co-design process would be within existing working routines, even if you are passionate about it:

“U l-workload, unfortunately, allura l-problema orrajt qed nitkellem miegħek hekk mil-ewwel, nerġa’ nieħu pjaċir u ngħid veru għandek raġun, kif nistgħu nagħmluha. Imbagħad it comes to day to day work, tara daqshekk nies. Imbagħad aħna li jiġri, imbagħad isu easier li mbagħad jerġgħu jintilfu l-affarijiet. Qed tipprova toffri servizz waqt li qed tipprova tamministra u tipprova tbiddel xi haġa”.

“And the workload, unfortunately, is another barrier. If I take today as an example, I am having this conversation with you and I am really enjoying it because it rekindles all the passion I have for these things and how interesting it is and start thinking in what ways can we achieve this. Then it comes to the day-to-day reality of work, and the caseload you need to take care of. What happens then, it becomes easier to get lost in the day-to-day things. The truth is that we are trying to offer a service, whilst at the same time you need to administer a lot of things, and at the same time be the driver for change. It’s a lot to put up with!”.

Service User 4 also mentioned that he would see persons not participating: *“...because they are busy at work”.*

Having such time constraints could lead to making rushed decision, as mentioned by

Professional 4:

“We have to be very careful how to involve experts by experience in a way illi ikollhom biżżejjed knowledge ta’ kif jistaw jużaw l-esperjenza tagħhom biex nippurvjaw s-servizzi. Dak huwa wieħed mil-izvantagġi li mill-ewwel jiġi f’mohhi; li forsi nkunu wisq mgħaġġla biex indaħħlu lil xi ħadd bħal expert by experience biex ikollna lil xi ħadd, mentri nemmen li għandhom ikunu nies ittrenjati speċifikament”.

“We have to be very careful in choosing experts by experience and ensuring that they actually do have enough of an understanding of how they can use their own experiences to make a valid contribution towards the improvement of our services. That is one of the first disadvantages I can think of; being in such a hurry to involve service users as experts by experience that we do not make sure that they are equipped with the necessary tools to make a valid contribution”.

Professional 8 believes in participating but mentions the same challenges, still emphasizing that the process would be worthwhile:

“Healthcare professionals should be heavily involved in designing the mental health services. This is because they are working one-to-one with the client on a regular basis. Unfortunately, the providers need to have the time for them to be able to do this since normally these services are heavily understaffed. The team needs to get to know the service users before the process starts, as this process takes time. But that’s how it is meant to be and it’s still worth to invest the time and energy I believe”.

Apart from the human resources shortages, participants in this study, like Professional 8, also mentioned funding shortages. Manager 4 said that: *“Another challenge is the existing gaps in services, where we do have resources but there is no funding available”.*

Manager 2 also stated that, in her opinion, co-design has not yet been implemented because:

“that is very simple. I think the money, the budget is not enough”.

Manager 3 also mentioned that the problem with implementation of co-design is:

“Ifhimni, naħseb li parti minnha finanzjarja”

“In part it's related to lack of financial resources...”

Professional 8 said that there is:

“...m'għandhomx biżżejjed flus to employ more people... m'għandniex biżżejjed employees biex jaħdmu mal-klijenti”.

“...lack of funding, there are just not enough funds to employ more persons which makes these initiatives more challenging”.

“Unfortunately, Malta, is-saħħa mentali ma ntuhix daqshekk importanza daqs is-saħħa fizika”.

“Unfortunately, in Malta, the mental health sector is not given the same importance as physical health”.

Lack of fair compensation for time and input, especially when service users contribute valuable lived experience, is also another point raised by a few participants in this study.

Professional 5 said:

“Mela aħna nithallsu, jien, kulħadd qed jithallas elfejn ewro, u din il-persuna fuq il-benefiċċji. We tried to work around this, imma dejjem issib il-bibien magħluqin”.

“Every professional is being paid a salary for his input on the initiative, but the service user, the expert by experience, gets paid social service benefits for his input. We have tried to work around this in the past, but the doors have always been closed”.

Professional 4 mentioned that:

“...l-iktar ħaġa li ddejjaqni hi li meta niġu biex niltaqgħubiex nippjanaw, jien inkun hemmhekk u nkun qed nithallas... dawn jiġu b'mod volontarju, mil-ħin tagħhom.”

“...what upsets me the most is that when we meet to discuss a way forward, professionals are being paid, whilst the peer expert is basically doing voluntary”

Għax ma teżistix l-ebda Sistema fil-public service illi nista nħaddem lil xi ħadd bħala peer expert at this point”.

work, as there is no system in the public service which allows for compensation of a peer expert”.

Manager 3 also said that:

“Jekk persuna tiġi mħallsa, aktar ikun hemm incēntiv, ejja ngħidu hekk. Dak li dejjem ħa jkun incentive li wieħed qed jipprova jtejjeb is-sitwazzjoni għall-qraba tiegħu jew għalih innifsu, imma fl-istess ħin, jekk ikun hemm dan l-incēntiv, tkun aktar tista’ tiġi formalizzata li forsi dak li jkun jipparteċipa iżjed in a holistic way, mhux isu just f area li hu ta’ interest għall-individwu”.

“If a person is paid, they will be more motivated. One would already be motivated to try to improve the situation for one’s relatives or oneself, but at the same time if there such an incentive the whole process could be further formalised and perhaps one could participate more in a holistic way and not just in an area that is of interest to one specific individual”.

Service User 4 also mentioned this point: *“People don’t participate for various reasons. But most of the time it’s because they are not financially free”.* He was also very eloquent, when asked by the researcher whether he would be interested in participating in a co-design process, to reply that he would, *“As long as it’s for money”.*

Finally, Manager 3 also referred to resource shortage in relation to venues.

“Anke affarijiet logistiċi, bħala premises... jew nies li anke, pereżempju, jiltaqqgħu flimkien biex jissoċjalizzaw, irid ikun hemm xi ħadd biex forsi jkun jista’ jiffaċilita din”.

But even logistical issues, such as appropriate premises to meet, as well as the need for someone to facilitate this process for service users.

Stability Over Transformation

Resistance to change was mentioned by some participants in this study that could discourage them or other similar professionals from participating.

Professional 5 said that: *“in reality...social workers are not really listened to straight away. Their arguments need to be first accepted by people in decision-making positions who can use the arguments/ case examples brought up by the social workers.*

When Service User 10 was asked by the researcher whether he thought that his ideas would be considered by professionals, he said:

“Iva, jiġu kkunsidrati, imma trid tara mbagħad jekk jiġu implimentati imma l-ideat, jew le”.

“Yes. they would be considered but one needs to see then whether my ideas would be implemented or not”.

In relation to resistance to change, Professional 5 said that:

“...so isu in some platforms it is accepted and then... imbagħad f’settings oħrajn, din tibqa’ ma ssirx, per eżempju, c-Change ma tigrix..

“...in some platforms, participation is accepted..., in other settings things are different and that’s why things remain the same and never change for the better”.

Professional 2 mentioned that resistance to change can hinder co-design implementation as:

“...being used to a stagnant working environment leads to less involvement because professionals might think a new approach would be unnecessary and would just break the ways we are used to”.

Manager 1 mentions resistance from professionals and society as a risk towards a co-design approach not being implemented:

“Jekk il-professionisti mhumiex on board u ma jemmnuh fjja, żgur li għandek l-ewwel barrier u kwazi kwazi barrier kruċjali ħafna. Plus hekk, s-soċjetà trid tkun aktar lesta għal dawn l-affarijiet”.

The mentalities of the professionals, if they don’t believe in it, it won’t happen. And society needs to be more prepared for these things. I don’t think they are ready to the introduction of service users in the planning stage of a service”.

Service User 10 also expressed that he witnesses this resistance and said:

“Ma jfissirx li jekk hemm ammont ta’ affarijiet li ilu hekk m’għandhom jinbidlu u jibqa’ l-istatus quo, speċjalment bil-mod kif naħsbu fuq is-saħħa mentali. Nothing is set in stone. Jekk taħllihom l-istess qatt ma tista’ tавvanza. Fis-sens, jien qed nitkellem mill-esperjenza. Ċertament affarijiet ġew deċiżi snin ilu u issa għandhom jinbidlu”

“It’s not necessarily the case that, if there are several things that have been long standing and implemented, they should not be changed, leaving the status quo, especially in the way we look at mental health. Nothing is set on stone, and things evolve continuously. If you never change anything, you can never move forward and advance”.

Professional 3 believes that resistance to change can also come from the government:

“Government can be a barrier, because it’s from them that things need to be endorsed. How can one trigger such a process without government being on board? It might be they are not interested in activating such processes, as the mentality is that there is no need for change. This doesn’t necessarily mean they would not care, just that they would not be open for such change”.

Professional 4 experiences resistance to change in his line of work, which leads him to believe that implementing a co-design approach might receive similar resistance:

“In terms of co-production aħna minn naħa tagħna qed nippruvaw. Qed nippruvaw kemm nistaw, mhux kuncett faċli biex tgħid lil management kif ukoll lil staff. Naqbel miegħek li għandha lura. Aħna nitkellmu anke sempliciment... indaħal l-expert by experience f’servizzi fejn mhux neċessarjament jinvolvu designing of a service imma, per eżempju, in terms of recovery. Nemmen, prinċipalment, għax ħafna nies ma jifhmux l-importanza tagħha u fl-istess ħin they tend to be in their own mindset in the way they are seeing it...”

“We have been trying very hard to implement co-production initiatives, but it is not easy to convince management as well as our employees. I agree we have a long way ahead. Nowadays, even involving the expert by experience in the recovery process is hard, let alone in designing a service. I believe that it’s mainly because many people still haven’t understood its importance, and they tend to be stuck in their own mindset...”

Nonetheless, he expressed that even though he experiences resistance to change in similar processes, he would gladly participate in a co-design process even:

“...mhux neċessarjament il-ħsibijiet tiegħi u l-pjanijiet tiegħi ta’ kif nara s-servizzi jiżviluppaw huma at par ma’ dawk li jixtieq il-management... jgħiduli toqgħodx tivvinta... Nista’ nifhem illi l-istatus quo, irridu jew ma rridux, jintogħob... Naħseb li għadni ma qtajtx qalbi, vera nemmen li se jkun hemm bidla... vera se jkun hemm bidla.

“...my vision for the development of services in general is not necessarily aligned with the one of the management...I am still told to stop suggesting new things, which they aren’t interested in...I can understand that change is hard, and that at times it might seem to be easier to leave things as is..., but I haven’t given up yet, I still believe that there is need for change, and that it will happen”.

Complex Process

The implementation of a co-design approach is seen by a considerable number of participants in this study as both a bureaucratic, lengthy, and time-consuming process, requiring sustained engagement, coordination, and flexibility from all stakeholders.

On this, Professional 5 said:

“...it is not engrained in our beliefs inħoss... għadna l-bogħod”

“...it is like the whole concept is not engrained into our beliefs, and it will take a while for it to implemented properly”.

Professional 2 said that one of the reasons why co-design has not yet been implemented might be due to its complexity:

“Maybe they think it’s too much complicated to be hearing out a lot of people, hearing out different ideas...this approach, it would always involve change and then there is that, change of budget, change of workers, you have to train everyone, do this and that. It’s a long process.

Manager 4 is afraid that co-design might not be successful due to excessive bureaucracy leading to delays in implementation:

“If something is decided upon, then it still takes a lot of time for it to actually happen, if it does happen. Also delay in taking decision, which then would also be connected to delays in implementation. Liaising with other entities other than your own is very difficult. Internally it’s easy to communicate but when you try to communicate with external entities, it becomes much more complex, so this could be a barrier to co-design as you need to put together different persons from different entities/workplaces”. She also mentions: “...the red tape that might be created for this to be implemented”.

From her end, Professional 5 said that:

“Hafna drabi wkoll hemm il-problema ta’ isu, different ministries have to come together to find a solution”.

“Another barrier is the need for different ministries to work together...”

Such bureaucracy can also bring along fragmentation. Manager 2 said that: *“even access to IT systems, why is it so difficult to view a resident’s file? Both our files and the government’s file should be merged into one integrated IT system, to be used throughout health”.*

Challenges in Participant Selection and Representation

Professional 5 express her worries for under representation, the worry of not reaching out to diverse service users and choosing specific ones for their contribution.

Professional 5 said:

“...#taġa li issa tinkwetani hi isu minn se jkun dik il-persuna, jiġifieri ta’ min se niehdu vuci? Għax il-vuċi ta’ dik il-persuna trid tkun rappreżentattiva, isu ta’ ħafna nies differenti, jiġifieri ma nistgħux nkejlu, nużaw il-kejl, ta’ persuna waħda biss, ma nafx jekk int tifhimni”?

“...selecting one service user to represent the whole spectrum does worry me. How can one select one single person who is expected to be a representative of many different people? We can’t simply cater for the needs of one person and expect them to cater for all the rest. I don't know if you understand me”?

She went on to say,

“Imma mbagħad isu l-inkwiet tiegħi, għax jien nesperjenza kwazi kuljum... minn se jkun l-advocate tal-persuni”?

“However, what worries me, as I happen to experience similar situations almost every day, what happens to the service users who have more demanding needs than the one you selected to be part of your co-design initiative?”

And that: *“...we have to be careful not to leave people out. And that is my concern, leaving people behind.*

A substantial number of participants in this study mentioned that, in some cases, poor selection of professional participants further undermines the process. These factors combined can reduce trust, limit diverse input, and ultimately challenge the effectiveness of co-design.

Professional 3 said that: *“It is very important to choose the right people for this process, and they know how to handle such processes”.*

Professional 7 attributes the poor selection to island dynamics:

“...jekk int għamiltli pjaċir, jien nagħmillek ieħor. Jekk int ħaqqek dik il-pożizzjoni għax

“In Malta we have this mentality of doing favours to each other to

*għandek beliefs tajbin u inti kapaċi tgħin lil
ħaddieħor, iva. Imma mhux għax tafni,
mbagħhad naraw x'jiġri.”.*

*eventually receive them back, so that
might work against the success of the
process. Persons might be appointed to
participate in the process even if they
would not be good contributors”.*

Manager 1 attributes this to professionals not being yet prepared to a co-design approach:

*“Jekk il-professjonisti mhumiex on board
u ma jemmnux fija, żgur li għandek l-
ewwel barrier u kważi kważi barrier
kruċjali ħafna. Plus hekk, s-soċjetà trid
tkun aktar lesta għal dawn l-affarijiet”.*

*The mentalities of the professionals, if
they don't believe in it, it won't happen.
And society needs to be more prepared
for these things. I don't think they are
ready for the introduction of service
users in the planning stage of a service”.*

Manager 2 stated that the successful implementation of a co-design approach: *“...depends on
how dedicated the people involved actually are”.*

4.6.2 Barriers to Service Users' Participation

This category groups several barriers to service users' participation in a co-design process, a few mentioned by the service users themselves.

The Risk of Re-traumatisation

In relation to her participation, Service User 3 said:

*“Jien naħseb tant għamilt affarijiet
f'ħajti li issa għajjajt, inħossni għajjiena
biex ngħin. Il-għarfien għandi – kapaċi
imma issa għandi għajjiena minn
x'għaddejt, mhux ma nixtieqx. Issa li
qed irtirajt, għandi l-paċi”.*

*“I think that I have gone through so
many things in my life that I now feel
tired of helping others. With the
knowledge I have, I could, but I am tired
from my experiences, and I don't wish to
do so. Now I am retired and all I want is
peace of mind”.*

Service User 10 would participate, but:

“pero trid tkun b’saħħtek psikologikament għalihom biex ma tħallix kemm il-persuni ta’ madwarek jeffettwawk kif ukoll l-istejjer li tkun qed tisma’. Trid tkun kapaċi wkoll ma titgħabbix bil-problemi ta’ ħaddieħor”.

“...but I would need to be psychologically strong for such a process not to let anyone affect me both with their attitudes as well as the stories I hear. One needs to be able not to take on the problems of others.”

Lack of Interest in Participation

A hindrance to the implementation of a co-design process which was mentioned by many of the participants in this study, was participation deficiency from service users.

Professional 3 believes that: *“Another barrier might be the lack of interest of service users to participate in such a process”.*

Professional 8 also mentioned this as a barrier:

“Eżatt, speċjalment older clients naħseb. Dik is-sens ta’ apatija, helplessness nara ħafna fix-xogħol tiegħi”.

“One barrier would be the possible lack of participation, especially from older clients. They are more apathic, which leads to helplessness in our line of work”.

She went further to say:

“Naħseb trid tara wkoll kemm il-klijent irid jaħdem fuqu innifsu biex tara jekk hi worth it. Għax I feel jekk ma jridx, mhux ma taħdimx miegħu, taħdem”.

“One also needs to take into consideration as well how committed is the client to work on himself/herself to be able to participate to see whether it’s worth the time or not”.

Professional 6 also said that:

“Xi ħaġa li ninnota isu biex jiġu involuti service users, they don’t come

“One thing I notice is that to get service users involved, they don’t come forward

*independently, they have to be invited...
jaqa' fuq il-professionals".*

*independently, but they must be invited
by a professional".*

From the point of view of the service users who participated in this study, a few also mentioned that they would not be interested or did not feel the need to participate.

Service User 2 does not believe he would need to participate:

*"Ma naħsibx li jkolli bzonn
nipparteċipa".*

*"I don't think there would be the need
for me to participate".*

*"Ma niddejaqx inkun parti imma ma
nafx jekk hemmx bzonn għax kollox
għamlu miegħi diġà".*

*"I wouldn't mind being part of it but I
don't know whether there is the need to
as they already know what needs to be
done, like with me, they did whatever
could be done".*

Service User 3 also said when asked about participation:

*"Ma naħsibx li nkun interessata għax
mhux se jifhmuni".*

*"I don't think I would be interested as I
would not be understood".*

Same goes for Service User 7:

"Għalissa m'għandiex moħħ".

*"I do not have the mindset for such
things right now".*

Managers who participated in this study mentioned a number of barriers they would see in having service users included in a co-design process.

Varied Service Users' Capacities

Manager 3 mentioned the difficulty in having different service users participating due to their varied capacities:

“Għax se jkun hemm min se jagħmel suggerimenti u jkun isu vokali ħafna u dan fejn jidħol complaints... jew suggerimenti, eja ngħid hekk... Se jkun hemm min isu kwazi trid tibbutah int ...”.

“There are those who make suggestions and are vociferous with their complaints or suggestions on one hand, and on the other hand there are those who need to be encouraged to talk...”.

Manager 4 also mentioned this and said that: *“...I see clients as not having insight or reflection ability to look into the difficulties which would lead to misinformed information/decisions. Obviously, this does not include every service user, but most of them.*

Manager 2 and Manager concur that not all service users would be able to contribute because, as Manager 2 states: *“...this obviously depends on the service user, on their condition, and their needs”.*

Service Users Behaviours

Participants in this study also view certain *behaviours* from service users as a barrier/risk.

Professional 8 said something similar:

“...għandna clients li, if you challenge them daqshekk, joħorgu mill-kamra, ħafna rabbja. So, we have to prepare biex tara kif se tikkalma l-klijent jekk fil-każ li se jirrabja jew jitlef il-kontroll”.

“There are certain clients that, if you challenge them, they will just storm out of the room. In such cases, those involved need to be made aware and taught or have someone to support on how to de-escalate the service user if such instance occurs”.

Professional 5 also believes some behaviours would work against this process:

“Li wkoll issib persuni li they are able to talk when they are, jiġifieri mhux, li jibqgħu professional, jiġifieri mhux li joqgħodu jtkellmu fuq il-problemi personali tagħhom within a setting,

“It is also hard to find people who are able to keep focused on the task at hand, rather than rambling on their current problems. They would be expected to keep a degree of

imbagħad forsi ċertu nies jarawhom mhux appropriate”.

professionalism, as otherwise other stakeholders might not deem their behaviour appropriate”.

Two of the service users who participated in this study mentioned treatment effects as a barrier to their participation:

Service User 11 said that: *“It’s after I take the tablets, and they settle down that I start coming back to earth. So, I would certainly need to be stabilised by the treatment for me to communicate effectively”.*

While Service User 8 said, when asked if she would be willing to participate in a co-design process:

“Ifhem jien ma tantx jien dan għax anke issa qed jaqbadni attakk nervużu”.

“I am not sure what to answer you. As I suffer from nervous attacks”

These risks and limitations must be acknowledged and addressed to ensure inclusive and meaningful participation in the co-design process.

4.7 Theme 4. Relational Barriers: Communication Breakdowns and Conflicting Visions

Two identified categories converged to form this overarching theme: Barriers to Dialogue and Shared Vision; and Professional Relational Barriers.

4.7.1 Barriers to Dialogue and Shared Vision

This category explores how relational barriers, especially communication breakdowns and misaligned visions, can undermine meaningful collaboration in co-design.

Communication and Cultural Barriers

Communication emerged as an important relational barrier to the implementation of co-design on both a professional and service user level. Professional 3 described how language limitations can prevent mutual understanding:

“A disadvantage I can think of is language barrier since not all professionals are able to communicate and understand well in the English language, and some service users don’t really understand English as well, so there might not be a proper communication which would lead to problematics”.

Manager 4 noted that service users may also struggle with expressing themselves in a way that is perceived as rational or aligned with decision-making frameworks, saying: *“Service users also have a lot of limitations to communicate as they tend to use emotional not rational ways to do so which leads to lack of objectivity for decision-making”.*

Manager 3 emphasized that even when a service user wishes to participate, difficulties in engaging in dialogue can inhibit effective contribution:

“Jekk persuna jsibha diffiċli isu biex jidhol fil-konversazzjoni, se tkun diffiċli ... xorta forsi jista’ jkun li dak li jkun jista’

“If a person finds it difficult to engage in the conversation, it will be difficult... they can still contribute, however,

jagħti opinjoni, imma forsi ma jkunx hemm daqshekk awareness ta' x'hemm bżonn li jintqal, jew biex jifhem x'ikun qed jintqal"

sometimes they might not be aware of what needs to be said or to understand what is being discussed"

This depends on the level of the service user's condition:

... għax jekk ikun forsi dak li jkun mild jew just below average IQ, forsi jkun jista' jagħmel suggerimenti. Aktar ma jkun hemm severe, jista' jkun hemm dik id-diffikultà li jidhol f'dan il-process".

"... those suffering from a mild condition, would be able to contribute, however, in more severe cases the condition itself creates barriers in the process".

Cultural barriers were also mentioned by professionals as challenges to meaningful co-design.

Professional 2 noted that beyond language, culture plays a key role in how people accept new ideas: *"It's always communication, language barrier, our own believes, cultural differences, the behaviour, how you accept things".*

Manager 3 supported this perspective, suggesting that cultural mindsets influence participation, even when the idea of co-design is theoretically accepted:

"...naħseb iż-żewġ kwistjonijiet huma ta' kultura għax in principle, meta titkellem man-nies, I am sure li kulhadd se jaqbel għax it makes a lot of sense".

"...I also think that it's a matter of culture because in principle, when talking to people, I am sure everyone agrees to such process, because it makes a lot of sense".

Defensiveness and Lack of Shared Vision

Professional 4 mentioned that professionals tend to fall defensive:

"...għandna t-tendenza li bħal speċi nieħdu għalina, immorru defensive. Tipo dawn kif qed jikkritikaw dan is-servizz mentri aħna qed għamilna l-literature

"...we have a tendency to fall defensive, taking the critique too personally, despite having studied and reviewed literature which depicts what is

reviews, rajna x'inhu jigri barra, got standards etc. Però ovvjament l-ilmenti ma jkunx one off, ikun kostanti. U għalhekk huwa importanti..., bħalma weġibt l-ewwel mistoqsija, l-ebda riċerka, l-ebda paper m'għandhiex tgħidlek l-esperjenza ta' dak l-individwu li ultimately se juża s-servizz".

happening with standards abroad. This critique is not a one-off occurrence, on the contrary it is quite constant, and it is important to keep in mind that, despite the fact that studying and reading papers does open up one's mind to new horizons, it does not provide you with a good understanding of the individual needs of our clients".

Vision misalignment can lead to frustration and reduce commitment as Professional 5 said:

"...l-aktar ħaġa li hi challenging u frustranti għalija hi li jien, flimkien ma' aġenziji oħrajn, is-sini xi kultant inħoss that we don't even acknowledge this together, jigifieri we don't even say it is a problem. We say it's not my problem anymore rather than coming together to try and see how to address gaps".

"The most challenging and frustrating thing is that I, along with other agencies, feel that sometimes we don't even acknowledge the problem. We say it's not my problem anymore rather than cooperating to try and see how to address our gaps".

Professional 4 also said that:

"...mhux neċessarjament il-ħsibijiet tiegħi u l-pjanijiet tiegħi ta' kif nara s-servizzi jżviluppaw huma at par ma' dawk li jixtieq il-management".

"Furthermore, my vision for the development of services in general is not necessarily aligned with the one of management".

Professional 5 feels that such misalignment might come from the inability to accept divergent perspectives:

"...gieli you are not allowed to talk fuq ċertu problemi li forsi taffaċċja fix-xogħol jew tikkritika... isu it's not so allowed".

"...sometimes it seems like you aren't even allowed to talk about the problems you encounter at work, constructive criticism itself seems to be frowned upon".

And she sees co-design as a way to address this problem:

"Iva, inħoss li huwa importanti li jkun hemm co-design u ħafna drabi l-affarijiet kif jarawhom forsi aktar top

"I think co-design is important as often what is perceived by top management with regards to certain services, does

management f'certu servizzi, ma jkunx ir-realtà ta' the person on the ground, what that person needs".

not tally with the reality of the person on the ground, or with what the person needs".

Manager 4 pointed out the importance of transparency to ensure that service users feel as comfortable and safe as possible: *"Transparency is also vital to ensure that everyone is on board with what is being discussed and the decisions to be taken and any challenges, obstacles can be immediately addressed in order to move on".*

4.7.2 Professional Relational Barriers

Participants in this study have identified a number of relational barriers what would undermine genuine collaboration.

The Reality of Power Dynamics

Power Dynamics were very present in the conversations with many of the participants in this study, explained by them as a hindrance to the implementation of a co-design approach.

Professional 5 said that sometimes, due to these power dynamics, it is also difficult to express your opinion and that: *"Sometimes it seems like you aren't even allowed to talk about the problems you encounter at work, constructive criticism itself seems to be frowned upon."*

She added that irrespective of the hard work, sometimes problems are solved differently:

"U li per eżempju ċertu nies forsi, jien naf, imorru jkellmu xi customer care ta'

"For instance, you might be trying hard to advocate for a person to get a service,

xi ministry biex igibu ċerti servizzi u isu it's not always how much we push, how much we advocate for a person to get a person that results in a person getting a service jew whatever".

but what gets the service underway isn't your hard work, but a complaint lodged with customer care".

She also said that in some settings:

"...anqas biss jgħaddilhom minn moħħhom li jkun hemm din l-idea ta' a person expert at the same level as other people. Imma, not even other people are at the same level".

"...they would not acknowledge the expertise of an expert by experience, they already do not acknowledge the expertise of other professionals let alone a service user".

In relation to her line of work Professional 5 added that:

".... there is a power imbalance and in practice, social workers are not really listened to straight away. Their arguments need to be first accepted by people in decision-making positions who can use the arguments/case examples brought up by the social workers".

Professional 4 also described barriers relating to power imbalances:

"Qed nippruwaw kemm nistaw, mhux kuncett faċli biex tgħid lil management kif ukoll lil staff".

"We have been trying very hard to implement initiatives, but it is not easy to convince management as well as our employees".

He further goes on to say that: *"I believe we lack input from professionals who work directly with clients on the floor, resulting in a top-down rather than a bottom-up approach".*

Professional 3 also links this imbalance to academic qualifications: *"...if service users are part of this process, their perspectives might be ignored by some professionals. At times, professionals believe that just because they studied, they know more, which is not necessarily the case".*

Same goes for Professional 7 who says:

"...għax xi kultant tkun kemm tkun għaref u bravu u studjajt, ikun hemm ċertu affarijiet li forsi pazjent jista' jgħid". *"Even if professionals have studied about the subject, it doesn't necessarily mean they know everything".*

She went on by associating power imbalances to the islands' size dynamics:

"Jista' jkun għax il-pajjiż żgħir u kulhadd jaf lil xulxin. Jew anke kulhadd irid iżomm ċertu poter fuq dak is-servizz... nibqa' dejjem jien fil-klikka". *"Maybe the fact that Malta is small, and we all know each other, which might lead to certain power dynamics and establishment of 'groups'. Apart from this, I feel that many professionals want to hold on to their 'power' positions and are not keen to let go of that".*

She goes further to say the following about whether professionals would see the inclusion of service users as positive:

"Naħseb min hu saqajh mal-art jgħid iva u min hu proud jgħid le. Iridu forsi jibqgħu huma on top. Imma m'għandux ikun hu. Għax after all is-servizz mhux għalihom, għal min qed nieħu ħsieb. Naħseb jien". *"Some professionals view the inclusion of service users in this process as positive, but some might be against. Some professionals think that they should always be at the top of everything, but that's wrong in my opinion. Because after all the service is meant for the service users and not for them".*

Professional 6 has no doubts that a co-design approach will experience strong power imbalances:

"Power relations – ħa jkollok... ħa jkun hemm power struggles kbar – għax jien professional u dak kif qed jgħid hekk? Dak m'għandux kwalifiki, l-esperjenza issa ma tgħoddx. Definitely li se jkun hemm hekk". *"Another disadvantage is power relations. There is absolutely no doubt that these will be present during a co-design process. Professionals would not agree with other professionals, they would question the ideas of persons who are not qualified, they would state that experience is not enough etc. "*

She also said that professionals would feel threatened to participate:

“Min naħa ta’ professionals nemmen ħafna li jista’ jkun iħossuhom threatened fuq kuntest ta’ power. Ovvjament mhux qed ngħid għal kulħadd, imma ċertu professionals, mhux bilfors professionals iżda anke nies li jkollhom ċertu power, forsi bħal policy makers, they look down on others”.

“From a professional standpoint, I believe that many might feel threatened in relation to power dynamics. I am not including every professional in my line of thought, but some professionals or persons who are in power positions, like policy makers, do tend to look down on others.

Manager 4 sees these power imbalances as a detriment to achieve better outcomes:

“Another barrier I can think of is the power struggle which will be created through this process... I think this is across the board and a common belief amongst many professional, which leads to unnecessary struggles between different persons ending up into decisions not taken at the detriment of the person using the service and the frustration on other professionals who would wish the best for the service users and that things happen”.

Professional 1 sees these power imbalances as a hinderance to an inclusive approach as:

“...some professionals might stick to their own mentality and are not open to suggestions and different perspectives and end up brushing away also valid input. This hinders the opportunity of an inclusive approach”.

The Strength of the Medical Model

A few participants of the study mentioned the presence of a dominant medical model in this sector, which they see being also present if a co-design process was implemented. This model challenges also the ability of certain professionals to contribute and participate, suggesting that it would be much more challenging for service users.

Professional 5 said:

“Fejn hemm dak is-strong medical model, anke persuna bħal social worker tibgħati, anke persuna bħal OT tibgħati. Mhux qed ngħid li l-medical model huwa ħażin, imma hemm setting fejn isu x’għid persuna waħda hija tajba and there is no room for any discussion from anyone”.

“In these fora, where a strong medical model is in place, even social workers and occupational therapists find it hard to contribute. I do not mean to say that the medical model within itself is bad, but in settings where there can only be one person who is right, and there is no room for discussion, it becomes hard to participate”.

Professional 4 also mentioned this as a big challenge:

“Pero, waħda mill-ikbar challenges li nemmen we are still very much dominated by the medical model... jġifieri anke meta niġu biex niddisjaw servizz, anke meta niġu biex niddiskutu policy”.

“Of course, one of the greater challenges revolves around the fact that we exclusively employ the medical model, whether it’s in designing a service or discussing a policy”.

This barrier was also mentioned by Service User 8 when she said that:

“...nagħti idea imma huma jagħtu l-pilloli ...”.

“...I would give ideas, but they give treatment...”.

Adopting a Paternalistic Approach

Paternalistic attitudes were also seen as a possible hindrance to co-design approach. In relation to service users’ ideas, Professional 4 said:

“Jiena naħseb li xi kultant... nippruvaw nwasslu l-persuna li hu expert by experience biex jasal għal konkluzjoni li rridu aħna”.

“I think that sometimes we try to lead the service user to the conclusions we believe we should be reaching”.

Professional 8 also mentioned this:

“...l-mod kif nara jien ħajja olistika hi differenti minn kif jaraha l-klijent, u dik domt biex nithgallima. Naħseb we impose a lot on the client x’inhu tajjeb għalihom, kif għandhom jgħixu u I don’t think it’s right”.

“...the way I look at a holistic lifestyle is different from the client’s perspective, and it took me a while to understand this. I believe we impose a lot on the client: thinking that we know what is right for them and how they should live their lives, and I don’t think it’s right”.

Professional 6 mentioned the way service users are usually involved in processes:

“Xi ħaġa li ninnota isu biex jiġu involuti service users, they don’t come independently, they have to be invited”.

“One thing I notice is that to get service users involved, they don’t come forward independently, but they must be invited by a professional”.

Professional 1 links paternalistic attitudes to their mental health condition:

“...ġieli narahom li tipo ma tantx jiġux emmnuti... ma tiġjex emmnuta direttament għax għandha mental health”.

“One of the barriers I see in co-design is that professionals might not believe service users just because they suffer from a mental health condition”.

4.8 Theme 5. Motivational Drivers & Perceived Impact of Co-Design

This single overarching theme was derived by aligning these identified categories: Motivation and Willingness to Engage; and Benefits of Co-Design.

4.8.1 Motivation and Willingness to Engage

This category represents those factors that would motivate service users and healthcare professionals and encourage them to engage in such a process.

Professional Growth

Professional 2 sees her inclusion in a co-design process as a growth opportunity and she says
“I see it as a growth. Being open to new things, especially this kind of strategy of co-design approach.”

Professional 1 also views her inclusion in such co-design as:

“...nibda nifhem kemm hi importanti li jiena nsaqsi lil min għandu hands on. U kemm hu importanti x’jixtiequ r-residenti”.

“a learning process for everyone which helps more in understanding both what the service requires and what the service users need”.

Opportunity to Help Others and Mutual Benefits

Professional 1 also sees this process as an opportunity to help. When asked by researcher whether she would be comfortable in joining a co-design process, that she would:

“Għax nkun sodisfatta, għax inkun qed ngħin aktar dawk il-persuni”.

“Personally, I would feel comfortable in participating in a co-design process as it would be a means to help service users even more”.

The same sentiment was also shared by Service User 1 who said that participating:

“Iva naccetta, inħobb jien. Nkun kuntenta ngħati l-kontribut, anke jekk għal ħaddieħor”.

“would be nice, even if not for myself, just to help others”

Service User 11 also pointed out that he would participate as there was mutual benefit and said: *“Yes, because it could benefit me as well and I use it”.*

Professional 2 agreed and said that: *“...you are not just building a team solely for the benefit of the organisation but as a whole, for everyone to benefit from it”.*

Professional 7 also said that:

“Naħseb li anke l-professjonisti jistgħu jjeħdu xi ħaġa minna”.

“I honestly believe that even the professionals would benefit from such a process”.

When explained the concept and purpose behind co-design, most service users answered affirmatively to their willingness to participate. Quotes have not been included as most were monosyllabic “Yes”.

4.8.2 Benefits of Co-Design

During the interviews, participants from this study mentioned several benefits that they perceive the implementation of a co-design process would bring along.

Involvement of Service Users and Person-Centred Outcomes

Professional 4 started of his interview by saying:

“Se nibdew mil-prinċipju li n-nies li se jużaw is-servizzi għandhom ikunu involuti ...”.

“Let's start with the principle that, the people who make use of the services should be involved...”.

Professional 6 believes in the importance of the service users' involvement:

“Co-design irid jibda mil-bidu nett sewwa għax fl-aħħar mill-aħħar is-servizz se jkun qed jintuża minn dawn in-

“Co-design is involving the service users from the start of the design because ultimately, they are the ones who would

nies innifishom. So għalhekk importanti – huma jafu x'esperjenzaw, x'għandhom bżonn, x'mgħandhomx bżonn”.

be using the service. That’s why their input is very important because they are the ones who are going through their experiences, and they are the ones who know what they need or what they don’t need”.

Another benefit mentioned by a number of participants in this study was that a co-design approach would give person-centred outcomes and services.

Professional 5 said that:

“...jekk hemm qegħdin nieħdu u noqgħodu fuq il-persuna x'għandha bżonn, ovvjament is-servizzi dejjem se jkunu isem person-centred, person-oriented.

“...if we are taking into consideration the needs of the service user, the resulting services will be more person-centred, person oriented”.

Professional 6 also said that by using co-design:

“...tista’ timxi iktar b’dak li għandha bżonn il-persuna, b’dak li l-persuna tixtieq”.

“...you can reach out more to what service users wish”.

Manager 1 believes in the importance of this too:

“Li inti tpoggi l-persuna fiċ-ċentru naħseb li hi l-fulcrum ta’ kollox ...”.

“Having a person-centred approach is very important...”.

Manager 4 goes on by saying that: *“Having different opinions lead to give a better service as well as having services which are tailor made”.*

Empowerment and Hope

Empowerment was mentioned by several professionals participating in this study as an important element which co-design would bring along for service users, as their voices would be heard, and they would gain more control over their lives.

Whilst Professional 8 mentioned how they can be empowered through gaining control:

“Naħseb waħda mill-akbar vantaġġi hija li qed isem fil-kontroll ta’ ħajjithom”.

“I think one of the main benefits is that service users can gain more control of their lives”.

Professional 6 concurred with the other participants and said:

“...ikun hemm empowerment ukoll. The person is not just a service user, you have a say, you have an opinion and your opinion is valid.”

“...the process is an empowering one for them, as the person is not just a service user, you have a say, you have an opinion and your opinion is valid”.

Manager 4 believes that participation in a co-design process would give feelings of empowerment and hope to service users: *“Empowerment plays also an important role and meetings with peers as previously mentioned can give service users hope that they too can make it”.*

Benefits for All Stakeholders

Another recurrent aspect participants mentioned was that they saw the implementation of a co-design approach as bring mutual benefits.

Professional 6 said that:

"...nemmen li jista' jkun hemm ħafna iktar customer satisfaction kif ukoll sodisfazzjon minn naħa ta' professionals u anke caregivers".

"...I believe it gives more satisfaction both from a professional point of view as well as for a care-giving point of view".

Professional 1 views the learning process that it would bring about beneficial for all:

"...nibda nifhem kemm hi importanti li jienera nsaqsi lil min għandu hands on. U kemm hu importanti x'jixtiequ r-residenti".

"It is a learning process for everyone which helps more in understanding both what the service requires and what the service users need".

Manager 3 also believe in the mutual benefits:

"Anzi aktar ma jkun hemm skill mix... biex dak li jkun speċi kulħadd għandu terġa' kapaċitajiet personali li isu dak li jkun we play to each individual's strengths for the good of the team and the service".

"The greater mixture of skills and opinions involved...which ensures that all these strengths are grouped and targeted for the good of the team, the service and the service user".

As well as service user Service User 11: *"Yes, because it could benefit me as well and I use it".*

Improving Quality of Life

Another aspect mentioned by one of the participants (Professional 5) seen as benefit was quality of life:

"...dawn se jkunu qed jgħixu ħajja ta' kwalità ħafna iktar għolja milli kieku kellhom jitpogġew fis-servizz, se ngħid hekk, one-size-fits-all, jew ikollhom imorru jien naf f'xi residenza bilfors, bir-regoli kollha tagħha. Jigjifieri, ovvjament, din hi vantaġġ li persuna tista' tagħzel li trid, mhux issa tkun at the mercy of what's available, se ngħid hekk.

"...will be living a life of much higher quality than if they were to be put on a one-size-fits-all service or must move into a residence, with all its rules. That is, of course, a great advantage whereby a person can choose and is not at the mercy of what's available".

Professional Satisfaction

Two participants to this study perceive this approach as bringing an element of satisfaction.

Professional 6 said:

"...nemmen li jista' jkun hemm ħafna iktar customer satisfaction kif ukoll sodisfazzjon minn naħa ta' professionals u anke caregivers".

"...I believe it gives more satisfaction both from a professional point of view as well as for a care-giving point of view".

Manager 1 also said that:

"Li naf li qed nagħmel xi ħaġa li hija x-xewqa tal-persuna bil-Malti filgħaxija, tpoggi rasek fuq l-imħadda aktar b'mod komdu li tisma', inti qed tilhaq dak li jixtieq jilhaq l-individwu".

"A certain degree of job satisfaction comes with knowing that the goals you are striving towards are actually what the patients you are caring for want".

Cost and Service-effectiveness and Producing Better Outcomes

Professional 6 mentioned that one benefit she sees in the implementation of a co-design approach is that it would be cost effective.

"Jista' jkun cost-effective ukoll għax jekk ovvjament is-servizz se jkun qed jilhaq il-goals u l-bżonnijiet tal-persuna, mhux se joqgħodu jinhlew f'ċertu rizorsi li forsi l-professionist biss, jew il-policy maker biss għandu f'mohhu li hemm bżonn... naħseb minn dak il-lat tista' tgħin ħafna".

"It can also be cost-effective, as through targeting specific goals and needs of the service users, one doesn't spend time and resources unnecessarily, that would have otherwise be spent if only policy makes or professionals ideas were pushed forward. I believe that it can be extremely helpful".

Manager 4 views such an approach as providing better outcomes: *"Having different opinions is beneficial for a better service and it can also lead to tailor-made ones. Listening to different ideas help in producing better results".*

Finally, Professional 4 views co-design as giving value added and providing service effectiveness:

“...in my experience, meta kelli l-opportunità li l-experts-by-experience ikunu involuti fid-disinn ta’ servizz jew ta’ policy, il-possibbiltà li jkun successful narah li jkun ikbar jien. That’s why I see the importance of it”.

“...in my experience, when we actually did get a chance to involve these “experts by experience” in the design of a service or policy, I felt that the potential for a successful implementation was greater, and that is why I see the importance of it”.

Sharing a Common Goal

The collaboration which co-design would bring about was seen as very important by the participants of this study as it can provide a unified vision for the benefit of all.

Professional 2 said that:

“...having that one main goal and interest, getting to know their ideas, working together as a team, not the company itself, but also doctors, even the relatives and when you have that main interest, I think the quality of care you are trying to establish for the patient it will be delivered well or realised”.

She further emphasised the benefits of a collaborative approach by saying that:

“I think it is important especially in mental health services and dealing with psychiatric patients because we just don’t work like, in silos, it needs to be a team involved in it, as well as the client and also the relatives I believe”.

Professional 7 sees co-design as beneficial as a vehicle to achieve this:

“Aftar naħseb ma jkun hemm ideat, aktar jista’ joħroġ l-aħjar għal għan wieħed. Naħseb li anke l-professjonisti jistgħu jieħdu xi ħaġa minna ...”.

“The benefit I see in co-design is the integration of a lot of ideas because, the more there are, the higher is the possibility that we get a better outcome towards the same goal”.

4.9 Conclusion

This chapter outlined the key themes emerging from the empirical data gathered from participants of this study. The next chapter will critically discuss these findings in relation to the study’s theoretical frameworks and existing literature.

CHAPTER 5: DISCUSSION

5.1 Introduction

The aim of this study is to explore the perspectives of various stakeholders within the Maltese mental health services sector on the concept of co-design to evaluate whether the implementation of this approach would be feasible in Malta.

Hence, this research provides insights on how stakeholders perceive a co-design process within a Maltese context, where such processes were never previously implemented, exploring how service users and healthcare professionals see their inclusion in it and what benefits and hindrances they think such a process would bring. The study also aims to explore the views of management on service users' involvement, to evaluate whether it would be feasible to implement this approach in Malta, thus helping to break down barriers and lay the groundwork for a more inclusive and effective mental health service model in Malta, in line with international best practices.

This chapter will discuss in depth main themes that emerged from the data analysis, which will offer insight into the practical, emotional, and systemic dimensions perceived by the participants on the implementation of a co-design process. This discussion will then address the research questions in sequence to evaluate whether such implementation would be feasible in Malta.

As highlighted in the literature review, there is a tangible gap in the understanding of the perspectives of stakeholders on co-design prior to its implementation. Most of the literature

explored these perspectives from individuals who had already participated in a co-design process and following their participation.

This chapter explores the core findings of the study through a critical and integrative lens, applying four theoretical and conceptual frameworks: Arnstein's Ladder of Participation (Arnstein, 1969), the Four Key Elements of Co-Design (Bate & Robert, 2007; Donetto et al., 2015; Sanders & Stapper, 2008), Systems Theory (Meadows, 2008), and Critical Theory (Horkheimer, 1972).

Each provides a unique yet interconnected perspective. Arnstein's Ladder of Participation provides a framework for judging how much power stakeholders hold; how much power decision makers give away. ranging from one-way forms of communication via consultation to full decision making and implementation autonomy for citizens. The Four Key Elements of Co-Design outline a way to think about how to engage ethically, inclusively, and effectively in co-design, through engagement, relationship building, capacity building, and co-creation. Systems Theory provides a structural and dynamic view on how different actors, institutions, and processes interrelate and influence one another. Critical Theory provides a lens for understanding power relations, marginalisation, and inequalities embedded within service systems.

By triangulating these frameworks with empirical data and the literature reviewed in the previous chapter, this discussion delivers a layered understanding of the dynamics shaping the perspectives on co-design in Maltese mental health services. The five overarching themes identified — (1) Valuing Lived Experience: A Foundation with Fractures, (2) Trust and

Psychological Safety: The Emotional Prerequisites, (3) Structural and Logistical Barriers: The Weight of the System, (4) Relational Barriers: Communication Breakdowns and Conflicting Visions, and (5) Motivational Drivers and Perceived Impact of Co-Design — are analysed below in depth, supported by participant insights and contextualised within current research and frameworks.

5.2 Thematic Discussion

Theme 1: Valuing Lived Experience: A Foundation with Fractures

This study presents strong evidence that the lived experiences of service users constitute a unique and indispensable form of expertise required for the design of mental health services. Both professionals and service users recognised that those who have directly navigated the mental health system possess distinct insights which are deeply embodied, emotionally grounded, and experientially rich.

Such insights demonstrate the depth of epistemic knowledge embedded in lived experience and align with the literature, affirming the importance of involving experts-by-experience in co-design to promote person-centred services (Cree et al., 2015; Palmer et al., 2019; Palumbo, 2016). Yet, despite this recognition and that participants like Service User 1 affirmed their capacity to meaningfully contribute, the data reveal a discouraging contradiction: lived experience is frequently valued in discourse but dismissed in practice. Several participants shared their views about the inability of most professionals to grasp what service users had experienced. As one service user noted, *“sometimes they might not be able to fully understand*

you”, indicating a hesitancy rooted in fear of being misunderstood. This reflects concerns by Chauhan et al. (2021) on under-represented voices still being excluded from co-design through a lack of structural inclusivity and sensitivity. This tension between declared value and operational disregard highlights a failure in translating acknowledgement into agency.

Professionals similarly voiced that their lived experiences were equally important through the tacit knowledge they had gained from working with service users. These perspectives highlight the essence of the engagement principle of the Four Key Elements of Co-Design as valuing the experiential and professional knowledge equally. As McKercher (2020) and Staley (2009) articulate, engagement is more meaningful when individuals feel valued by their knowledge.

According to the participants’ perspectives, lived experience is embodied knowledge, forged in people who have lived the life of a person who has been significantly impacted by mental illness, or who has worked in close alliance with those so affected. While professionals and organisations may acknowledge the importance of service user insight, their actual decision-making frameworks rarely reflect such inclusion.

This theme also reveals the double bind of tokenism, which, apart from showing bad practice or random oversights, sends signals of entrenched structural hierarchies. Service users are invited into spaces of supposed collaboration but often without the tools, trust, or power to influence outcomes. The result is a paradox: their presence is used to signify progress, even as their voices are diluted and dismissed. This performative inclusion, as Beresford (2013) and Pinfold et al. (2015) warn, reinforces professional dominance under the guise of inclusion, offering the appearance of equality while preserving control, and involuntarily reinforcing

systemic control, unless co-design is actively applied in redistributing power through community ownership.

Drawing upon insights from Critical Theory, this study argues that, while the discourse around inclusion might have gained prominence, institutional hierarchies still prevail and privilege professional expertise over lived experience, leaving participants in the present study feeling undervalued, marginalised or disempowered whilst generating systemic inequity behind the front of participatory reform.

There is a specific kind of disempowerment which comes from being devalued through inclusion and not from being left out of a decision. Service users in this study, like Service User 9, articulated the frustration of being invited to share her opinion to ameliorate services only to find out that her contribution was either sidelined or absorbed without a meaningful response. This describes epistemic injustice and aligns with literature critique by Donetto et. al (2015) and Rose and Kalathil (2019), amongst others, who claim that user engagement often remains fixed in symbolic consultation, with no shift in decision-making authority. It also reflects what Arnstein (1969) conceptualised as the middle rungs of the “Ladder of Participation”: consultation and placation, where input is solicited but not acted upon. As one participant put it, they were *“heard, but not listened to”*, a distinction that captures the emotive weight of being present but powerless. The emotional toll of not being considered undermines the intent of co-design and inflicts harm by re-enacting patterns of invisibility and exclusion.

Systems Theory helps explain how this pattern persists. Without structural feedback loops, capacity building, or mechanisms for shared authority, any initiative which is participatory in nature, like co-design, becomes unsustainable. Organisational cultures that remain siloed and risk-averse lack the ability to embed lived experience into service design in meaningful ways. The system resists the very knowledge it claims to value (Meadows, 2008).

From this perspective, mental health systems are not neutral spaces but are organised in ways that serve to perpetuate professional power and structural injustice. Service users, especially those with complex or stigmatised conditions, end up being positioned as passive care recipients, with their ways of knowing mediated by professional expertise, and their lived experience de-legitimised or else pathologised. Thus, the call for co-design must also be a call for social justice, where lived experience holds epistemic legitimacy and thus power in shaping services (Beresford, 2013; Pinfold et al., 2015; Rose & Kalathil, 2019).

To conclude, this study challenges the assumption that recognising lived experience is sufficient for transformative co-design. Instead, it argues that unless institutional practice is ingrained with mechanisms for power re-distribution and co-creation, participation will remain a performative exercise, one that supports rather than disrupts hierarchical norms. The road to genuine inclusion, apart from requiring acknowledgement, needs structural realignment and a redefinition of who holds knowledge and power in mental health reform.

Theme 2: Trust and Psychological Safety: The Emotional Prerequisites

This study argues that trust is the emotional terrain upon which co-design must be built and not just a condition of participation. For people who may have experienced being judged, silenced or pathologised by mental health services, like some of the participants in this study, the invitation to share their story is not neutral and can be a risk, as they would be re-entering spaces within which their voice may have previously gone unheard or erased, making participation both personal and procedural. This requires the kind of psychological safety that cannot be assumed but must be cultivated.

Findings from this study showed that experiences of invalidation led many service users to approach opportunities, where they have been asked for their participation, with caution. Their caution should not be mistaken for disinterest, but rather as a protective armour against further marginalisation. As the data suggests, just being heard is not enough; what matters is being believed, respected, and treated as a credible narrator of one's own life. Without this, participation becomes hollow, and the emotional labour of engagement goes unmet.

Many participants in this study revealed that participation was emotionally taxing without clear conditions of safety and validation. Reflecting on experiences, service users shared feelings of being dismissed, misunderstood or judged by professionals and suggested that these experiences influenced their rather guarded participation towards participation, like Service User 3 who was sure that *"had I to share, they would judge me"*. This resonates with the findings of the trauma-informed care literature, which suggests that service users need

emotionally safe spaces where their experiences are respected and validated to avoid re-traumatisation and mistrust (Mulvale et al., 2019).

The need for trust was a recurring narrative in the interviews. One participant noted, *“until I earn trust towards the person, I am not comfortable. Trust is essential.”* Similarly, professionals acknowledged that trust must be cultivated over time through relational engagement. As Manager 2 explained: *“You need to understand that the service user will not trust you immediately. It is important to build a bond ...so the person starts trusting you and therefore providing you with fruitful answers”*. These insights, collected in the findings of the study, reflect the core principles of the Four Key Elements of Co-Design, which underscore trust and relationality as prerequisites for meaningful collaboration (Bate & Robert, 2007; Donetto et al., 2015; Sanders & Stapper, 2008). They also resonate with literature stating that trust may be built gradually through consistent and respectful engagement practices, to offer safety to vulnerable individuals for voicing their opinions (Larkin, Boden, & Newton, 2015).

Trust comes through relationship building, which, apart from being a soft skill, is the bridge for engagement to move from tokenism to transformation. Current systems in Malta need to invest much more in this relational work, since this is a way of creating space for voices but also a way towards healing, where meaningful co-design can begin.

The need for relationship building is explicitly highlighted in the Four Key Elements of Co-Design. It is classified as an important element in its own right, but trusting relationships also facilitate the kind of respectful interpersonal dynamics that allows for other elements of co-design to occur. The importance of investing in relationship-building is underscored by

Zechmeister-Koss et al. (2023), who emphasise the need for participants to dedicate time to dismantle pre-existing professional hierarchies and cultural barriers. Yet, this trust was often fragile or absent during the study. Many participants in the study described self-censorship, avoidance, or retreat in the absence of psychological safety. The lack of psychological safety leads to stifling of voice but also to self-effacement, like Service User 1 who said: “I would need some encouragement... I think I’m not good enough to participate’.

This internalised stigma was not an isolated case but indicative of a broader systemic dynamic, one where service users question the legitimacy of their presence and contribution, illustrating how trauma can silence through absence of trust. Topor and Ljungberg (2016), address the emotional and ethical complexities of developing enduring therapeutic relationships and identify some of the challenges associated with the establishment of trust within environments still shaped by hierarchical structures.

Arnstein’s Ladder of Participation (Arnstein, 1969) provides some theoretical insight into these findings. It highlights how tokenistic forms of involvement, such as informing and consultation, equate to the lower rungs on the ladder where power and impact are minimal and participation is passive. This study illustrates that where there is a lack of psychological safety, service users remain restricted to the lower rungs, unable to progress towards authentic participation. Tokenistic participation is harmful on an individual level, but it also perpetuates system level power imbalances that favour professional over experiential knowledge, as mentioned in Theme 1.

Critical Theory offers further insight by uncovering the unequal power relations that shape these dynamics. Professionals, even when well intentioned, may unknowingly endorse dominant models that silence alternative voices. As one participant observed: *“Being in a room with persons you don’t know would make some feel uncomfortable and intimidated... service users might feel judged”*. One of the managers also highlighted that formal clinical settings, such as those involving psychiatrists with professional attire, could provoke fear and silence from participants. These statements emphasise that it is wrong to make assumptions regarding the safety of co-design space; safety needs to be ensured through conscious design and cultural competence.

Participants highlighted the need for support networks, a structured approach and open communication for co-design to be successful and meet these emotional pre-requisites. Service User 8 said, *“I would need words of support and comfort...maybe a psychologist to guide me”*. This relates to capacity building, which is one of the Four Key Elements (Bate & Robert, 2007; Donetto et al., 2015; Sanders & Stapper, 2008). Without adequate preparation and ongoing support, even the most willing service users may not feel confident, clear or able to participate fully.

There is much discussion in the literature about the need for trauma-informed, inclusive settings (Faulkner et al., 2021; Tindall et al., 2021). These authors emphasise the need for preparatory work, debriefing and ongoing support to enable service users living with the impact of complex trauma to participate more fully.

The study's findings confirm the relational and recovery-oriented ethic outlined by Slay and Stephens (2013), which further advocates that, without a trauma-informed approach, participation is limited and potentially harmful.

Systems Theory teaches us that organisations must develop feedback loops and adaptive mechanisms to maintain trust over time. In the absence of these mechanisms, service users perceive a lack of dependability and predictability that further diminishes the scope for genuine co-design.

In conclusion, trust and psychological safety are fundamental to ethical and effective co-design. Their absence inhibits participation and actively undermines the potential of collaboration, repair, and transformation. For co-design to succeed, systems must create the conditions under which service users feel safe enough to stay, speak, and shape the conversations.

Theme 3: Structural and Logistical Barriers: The Weight of the System

A consistent and very concerning finding from this study is that the greatest challenges to meaningful co-design are institutional. While both service users and professionals expressed a clear willingness to participate in co-design, their participation efforts in similar processes were frequently undermined by the structures most likely to be supporting it. These are deeply ingrained barriers within bureaucratic, under-resourced, and hierarchical systems which, whilst adopting the language of inclusion, fail to allocate the resources, flexibility, and

cultural change needed to realise it. These challenges are reflected in the literature, like Bowen et al. (2013) and Bowen et al. (2010), who have identified weak governance, high staff turnover, limited funds and limited managerial support as ongoing barriers to systematic co-design. Dudau, Glennon, and Verschuere (2019) argue that the idealism associated with co-design initiatives is frequently subverted by institutional inertia and a disjunction between strategic ideals and practical implementation.

Such structural inertia and contradiction between rhetoric and reality accords with what Donetto et al. (2015) and Palmer et al. (2019) describe as the 'implementation gap' or 'policy-practice gap' in co-design. These are the spaces that exist between the aspirations of collaboration and the realities of institutional limitations. Manager 4 pointed to the gap between policy agendas and practical outcomes, noting the excessive bureaucracy which could prevent the implementation of co-design. She also noted the *"delay in taking decisions, which then would also be connected to delays in implementation"*, and that coordinating with external entities is far more complex than internal communication, creating a real barrier to co-design, which requires collaboration across different agencies and systems. From the lens of Professional 4, the most promising initiatives are many times stifled due to resistance from leadership. These reflections show how institutional inertia destroys the transformative potential of co-design.

Bowen et al. (2013) further note that many health systems claim a commitment to patient-centred care and patient engagement in principle, yet lack the structures, leadership support and flexibility needed to enable such engagement. Service User 10s resigned remark, *"it's*

useless that I participate. They won't bother to hear what I have to say", is a stark reminder that exclusion is often experienced through symbolic participation that lacks follow-through.

Beyond structural challenges, the emotional cost of systemic barriers is significant. They destroy confidence, bring fatigue, and cause a deep sense of helplessness over time. Both service users and professionals described a cycle of effort without results and feedback without impact, reflecting a form of systemic disempowerment where participants repeatedly give their time and emotional labour with no action taken as a result, leading to resignation. Through its non-responsiveness, the system signals that contributions are disposable. These accounts reveal how deeply entrenched structural inadequacies undermine people's sense of hope and agency, reiterating Beresford's (2013) assertion that without structural accountability, involvement and participation risks being tokenistic, rather than a channel for meaningful reform.

Practical demands of participation, like the effort and time investment required in a system which is already overloaded, further compound this emotional fatigue. Time constraints were mentioned by several professionals, who pointed out the challenges of balancing direct care with participation in similar participatory efforts. As Professional 3 put it, *"...we don't have time to do new things... but somehow, we can always make time, it's just a matter of willpower."* Meanwhile, Professional 8 acknowledged that "normally these services are heavily understaffed," making meaningful involvement difficult despite its value: "this process takes time. But that's how it is meant to be and it's still worth to invest the time and energy I believe." Similarly, Manager 3 stated that workload is a barrier and that *"The truth is that we are trying to offer a service, whilst at the same time you need to administer a lot of things, and*

at the same time be the driver for change. It's a lot to put up with!". The time-consuming nature of co-design was also emphasized by Professional 1, who explained, *"It takes time to organise... until you decide, choose, and come to a conclusion—I think it takes time"*. These statements reflect what Donetto et al., (2015), said that, even when opportunities for participation arise, clinicians frequently encounter barriers related to shift patterns and staffing levels.

Beyond time constraints and workload pressures, participants also emphasised the critical role of funding availability, with several describing how financial limitations acted as a foundational barrier that compounded all other systemic challenges to co-design. Manager 2 strongly stated that the main reason co-design had not yet been implemented was *"very simple I think — the money, the budget is not enough"*. Similarly, Manager 3 pointed to the financial underpinning of systemic inertia: *"In part, it is related to lack of financial resources"*. Manager 4 extended this critique to note that, even where resources exist in principle, *"there is no funding available"*, highlighting a structural disconnection between service ambition and financial investment. Professionals reflected similar thoughts, with Professional 8 said that *"lack of funding, there are just not enough funds to employ more persons which makes these initiatives more challenging"*. She further reflected that mental health in Malta keeps being under-prioritised when compared to physical health, stating, *"Unfortunately, in Malta, the mental health sector is not given the same importance as physical health"*.

These finding echoes those of Bowen et al. (2013) who, as mentioned in the beginning of this chapter, identified limits on funding, amongst other, as important barriers which inhibit participatory reforms from taking root. The perception that mental health remains a

marginalised sector in both symbolic and material terms constitutes a significant contextual barrier to the kinds of systemic investment that is required to embed co-design.

Adding to structural barriers, participants described logistical barriers that while practical in nature, were heavily impacted by systemic shortcoming. Service fragmentation, resistance to change, and service users' behaviours were mentioned by participants as perceived barriers to co-design. These logistical challenges compounded by systemic shortcoming, echo those reported by Ní Shé et al. (2019), which particularly highlight the need to ensure health equity of access especially for seldom heard voices. Similarly, Scanlan et al. (2020), found that involvement of service users was frequently superficial, or one-off in nature, due to lack of preparation and or support. Without capacity-building efforts, through structured support, training and or psychological preparation, co-design can easily become a tokenistic exercise even when efforts for inclusion are made.

Another significant structural barrier to effective co-design identified in this study is the lack of appropriate compensation for service users. While professionals participating in the research recognised the critical contributions service users could make, they also highlighted that service users are often expected to contribute voluntarily, with no financial recognition for their time, expertise, or emotional labour. Professional 5 criticised the prevailing system where professionals receive salaries for participating in planning processes while service users, many of whom survive on minimal benefits, are asked to participate without remuneration. Manager 3 explicitly linked financial incentives to greater motivation and fuller involvement, while service users, such as Service User 4, clearly indicated that lack of financial freedom was a practical impediment to involvement. This also concurs with Bersford (2013),

who notes that the recognition of a service user's contribution is key to involvement. Viewed from a Critical Theory perspective, this context reveals the degree of structural inequities that are present in co-design practices, where social structures that seek to enable service users to be actively involved, sideline their access to power, inclusion and socio-economically predetermined hierarchies.

A pragmatic, but emotional consideration mentioned by professionals was about the potential behaviours of service users during such processes. Their concern was that some might respond unexpectedly or have difficulty maintaining focus to participate without appropriate support. Professional 8, for instance, explained that *"there are certain clients that, if you challenge them, they will just storm out of the room"*, and therefore preparation and de-escalation were vital. In capturing a small element of this concern, Professional 5 stated that some stakeholders might end up using the space to re-enact their personal issues: *"They are expected to keep a degree of professionalism, as otherwise other stakeholders might not deem their behaviour appropriate"*. This also echoes what Chesterman and Bray (2018) and Hall et al. (2023), said that many service users' participation in the co-design process struggle to articulate constructive feedback towards the service, even when they are prompted to do so by the facilitators.

While these concerns are a realistic account of frontline dynamics, they also contest the need for trauma-informed facilitation that embraces emotional expression rather than exclusion. Heerings et al. (2022), explain that engagement methods need to be sensitive to emotional and relational dynamics, especially in mental health contexts, so behavioural expressions of emotions can be contextualised rather than pathologised.

Building on these emotional consequences, participants also identified disengagement as a deeper withdrawal or apathy stemming from repeated systemic failures. In the words of Professional 5: *“We say it’s not my problem anymore rather than coming together to try to see how to address gaps”*. This refers to a kind of institutional fatigue which stems from repeated failures to implement, undermining the collective motivation and trust necessary to support action. From a systemic perspective, disengagement can be understood as a manifestation of unresponsive feedback loops, where input is sought yet not demonstrably acted upon. As pointed out by Moll et al. (2020), without ongoing reinforcement and feedback, even the most willing contributors would lose interest.

What emerged most powerfully from this theme was the sense of exhaustion, a quiet, enduring fatigue, that participants conveyed in the face of structural resistance. Their stories displayed irritation at bureaucracy or frustration with red tape but also pointed to something deeper: the emotional exhaustion of constantly showing up to a system that demands engagement but resists change. This exhaustion is symbolic apart from emotional, revealing deeper truths about who is expected to adapt and who is supported in the process.

In this sense, logistical barriers are systemic signals that indicate this. As Dixon-Woods et al. (2021) and Tambuyzer & van Audenhove (2015) state, the effectiveness of co-design relies on robust leadership, clearly defined objectives, and sustained involvement from service users, yet the systemic complexities and sensitivities inherent in mental health care often limit genuine participation. When systems make no consideration of access, comfort or clarity, they are clearly stating that participation is a privilege that belongs to the resourced, the healthy,

or the confident, making this is an uneven playing field that, sooner or later, leaves the most marginalised voices behind.

Systems Theory highlights the concept of leverage points - places of focus within a system which enable small changes to have a big systemic impact (Meadows, 2008). A relevant leverage point in co-design may be workforce participation, whereby strategic focus is given to frontline professionals leading change between management and service users. Organisational culture, leadership approach and communication between different parts of the organisation must also be aligned for participatory practices to flourish. Authors like McAllister et al. (2021); Moll et al. (2020) and O'Brien et al. (2021); suggested that structural elements, such as staff support networks and regular reflective places, are key for engaging staff in co-design initiatives.

This study highlighted what prevents participation, but also how these barriers are felt emotionally and psychologically. Participants described feeling discouraged, disengaged, and invisible. Conditions such as cognitive impairment or the impact of long-term treatment were mentioned as difficulties in contribution. This reiterates the need for trauma-informed, flexible, and supported approaches to engagement, as suggested by Heerings et al. (2022), who underscores the importance of giving due consideration to emotional and complex relational aspects towards creating safe participatory experiences, especially for vulnerable populations.

A further dimension of these structural and cultural limitations is the issue of underrepresentation and the poor selection of professional participants. Some participants

expressed concern that, if co-design processes were formally initiated, those chosen to participate may not be truly representative of the diversity of perspectives and experiences required to bring about meaningful change. Professional 5 expressed her worries on *“selecting one service user to represent the whole spectrum”* since one person cannot represent the needs of many, emphasising the importance of not leaving anyone behind. This also reflects concerns raised by Palmer et al. (2019) on how selective inclusion can dim the diversity of lived experience. On the other hand, Professional 7 questioned the reasons behind the potential selection of professionals, suggesting that candidates may be selected due to familiarity to decision-makers or favouritism rather than on competence. This resonates with the critique by Beresford (2013) of systems that exclude marginalised voices or select participants based on convenient criteria. Particular attention in the selection process of candidates needs to be given for a successful co-design process, which needs to be purposive (Zechmeister-Koss et al., 2023).

In Arnstein’s Ladder terms, this is where things often come to a standstill: the middle rungs of consultation and placation, where power remains top down and there is no real influence once input is submitted. Structured, long-term approaches, which embed participation into both systems and culture, are needed if we are to progress to genuine citizen control. As Systems Theory and Palmer et al. (2023) argue, meaningful change demands a shift in attitudes, interactions, and robust systemic support.

In summary, structural and logistical barriers prohibit and define the possibility of engagement. Without an institutional desire to strike down these barriers and support the system-wide commitment required for deep engagement, co-design becomes a performative

exercise. It has commonly been regarded as: well-meaning yet disconnected from meaningful transformation.

Theme 4. Relational Barriers: Communication Breakdowns and Conflicting Visions

Effective communication is crucial to the translation of authentic co-design, yet findings from this study illustrate how communication between professionals and service users is often compromised. Participants identified a variety of factors which together undermine the development of mutual understanding, from language limitations and restrictions in emotional expression to assumptions relating to users' capacity to contribute. Collectively, these problems highlight more fundamental relational failures in how stakeholders engage with, construct and make sense of one another, than the practical transmission of information. In the context of mental health services, where power hierarchies and stigma are already embedded in the culture, such communication failures risk reinforcing marginalisation rather than encouraging collaboration.

The communication barriers identified in this study are primarily interpersonal in nature, with professionals demonstrating defensiveness, dismissiveness and little active listening. These difficulties are relational rather than policy or structurally based, arising in the ways in which individuals interact with each other. While systemic shortcomings may underpin some of these issues, the data reveal that it is often the relational enactment of these shortcomings that undermines collaborative efforts, such as how critique is received, how understanding is expressed, or how dialogue is facilitated. In this theme we highlight how communication barriers reflect their embeddedness in the interpersonal and power relations dynamics of

everyday practice, and the ongoing need to develop communication approaches based on mutual respect, emotional safety and reflexivity.

As noted by Palmer et al. (2019) and Tindall et al. (2021), active participation is genuine engagement, which is only enabled by effective communication and alignment of objectives.

The presence of defensive communication from professionals emerged as a particularly salient challenge in the data. One professional openly reflected: *“We have a tendency to fall defensive, taking the critique too personally... despite having studied and reviewed literature... it does not provide you with a good understanding of the individual needs of our clients”*. Even if well-intentioned, this reflects a broader institutional reluctance to release power. Such defensiveness blocks dialogue and reinforces professional hierarchies that inhibit true participatory co-design (Donetto et al., 2015; Rose & Kalathil, 2019).

While cultural norms can reflect broader systemic issues, in this study, they were expressed most often through day-to-day interpersonal interactions and assumptions, such as defensiveness, resistance to critique, or fixed beliefs about who should contribute. For this reason, cultural barriers are treated here as relational, rather than structural. They manifest in how individuals relate to one another within the co-design process, influencing tone, receptivity, and trust in collaborative settings.

Professionals highlighted that service users and staff frequently lacked a fluency in the language, or cultural interpretation. *“It’s always communication, language barrier, our own beliefs, cultural differences...”*, explained one participant. This captures the complexity of the

interplay between structural and relational components of Systems Theory, where parts of a system operate antagonistically, resulting in a disordered hierarchy of objectives or feedback cycles. Sanders & Stappers (2008) emphasizes the futility of fragmented design processes by stating that, without shared meaning between users and professionals, design processes will remain fragmented and ineffective.

The severity of service users' mental health conditions also emerged as a factor in communication breakdowns. One manager stated, *"Those suffering from a mild condition would be able to contribute, however, in more severe cases, the condition itself creates barriers in the process"*.

This echoes literature saying that even though managers recognize the value of service user input, they still express concerns about client vulnerabilities and the skills required for effective participation, creating a duality that raises inclusivity concerns as those without adequate skills may be excluded, undermining the authenticity of their involvement and diminishing their contributions to service design (Cox et al., 2022; McGowan et al., 2024; Ocloo et al., 2021; Visser et al., 2024).

This adds a dimension of complexity in which cognitive and emotional readiness, as well as the systemic design, would determine the success of communication efforts in co-design. From a Critical Theory perspective, privileging professional discourse over experiential knowledge reinforces existing hierarchies within co-design and undermines co-design's aims of inclusion. The Systems Theory framing helps explain how fragmented sub-systems (departments, professional roles or policy domains), communicating with an absence of

commonality or coherence with overlapping stakeholders and multiple touchpoints, produce siloed, dissonant messages.

Another communication breakdown lies in the discrepancies between frontline understanding and top-level decision-making. As one of the participants stated, *“vision for the development of services in general is not necessarily aligned with that of management”* because *“what is perceived by the latter does not tally with the reality of the person on the ground, or with what the person needs”*.

This fragmentation was also mirrored in comments like, *“rather than cooperating to try and see how to address our gaps, we say it’s not my problem anymore”*, revealing that misaligned visions led to disengagement. Similarly, the comment by Service user 8, *“I would give ideas, but they give treatment”*, encapsulates the disconnect between user’s voice and professional response, affirmed the warnings by Donetto et al. (2015) and Visser et al. (2024), about the risks associated with failed alignment of organisational and stakeholder goals, noting that breakdown in communication frequently reflect deeper tensions in institutional values and power structures.

These dynamics underscore certain features of the predominant medical model as a bias towards professional knowledge, rather than knowledge gained through experience and lived reality. As numerous professionals pointed out, this fosters hierarchical, clinician-centric decision-making structures rather than more dialogic and participatory ways of engagement. Professional 5 remarked that in places dominated by the medical model, even non-medical professionals, like social workers and occupational therapists, struggle with having their

perspectives considered, let alone service users. Hierarchical and rigid cultures tend to suppress collaborative practice, while equally reinforcing a lack of agency in those people most eager to help the system improve (McGowan et al., 2024; Visser et al., 2024). The continued adherence to a medical model of care undermines the possibility of shared authority (Donetto et al., 2015; Palmer et al., 2019; Rose & Kalathil, 2019).

The medical model persists without critical scrutiny - there is no questioning the fact that it overwhelmingly dominates discourse around mental health, which is the treatment of an ailment rather than conversational engagement and co-designing experiences. There is an over-reliance on vertical communication pathways, which are inherently unidirectional, paternalistic, and define the service user as a passive participant rather than an active role player. The suppression of open dialogue results in clinical authority being given too much control, through preventing widening debates to diverse opinions options. This lack of inclusive dialogue stagnates the co-design process that fosters respect, shared authority, and constant feedback.

Critical Theory draws attention to the operation of power in producing these obstacles to communication. The marginalisation of service users' voices, and the centring of professionally curated knowledge, speaks to the history of epistemic injustice where one form of knowledge (clinical, professional) is systematically privileged over another (lived experience). These account for the comment by Service User 9, "They won't [listen]... why would they want me?", showing how internalised exclusion and institutionalised disempowerment continued, even when invitations to participate are made.

Despite these barriers, the study also found that participants believed that where communication was clear and visions were aligned, co-design could flourish. Professional 2 noted: *“When you have that main interest, I think the quality of care you are trying to establish for the patient will be delivered as well”*. This confirms that clarity, trust and relational cohesion are not supplementary, but core components of effective co-design.

To conclude, without transparent communication, common goals, and equitable valuing of all contributions, co-design is vulnerable to fragmentation and power imbalances. To reach its full potential, organisations need to invest in the relational and communicative infrastructures through which transparency, empathy and mutual understanding can be supported.

Theme 5: Motivational Drivers and Perceived Impact of Co-Design

Co-design has the potential to empower participants and transform systems, but only when supported by structures that value, implement, and act upon contributions. Notwithstanding the structural constraints and emotional challenges that threaded through earlier themes in this study, there is evidence that participants see co-design as offering potential for growth, empowerment and collective transformation.

This theme demonstrates the way the process is perceived as satisfying, whereby there is a potential to generate mutual benefits and better outcomes if collaboration, a shared vision, and teamwork are integrated. Professional 6 stated that co-design can be *“empowering...you have a say, you have an opinion, and that opinion is valid”*, while Professional 2 sees her

potential participation as *“a growth”*. Such views reflect the findings by Clarke et al. (2017), who argue that co-design can renew professionals’ intrinsic motivation and even shift the culture of organisations by reinforcing purpose and empathy. Donetto et al. (2015), describes co-design not only as a methodological tool but also as a relational practice, with the capacity to cultivate humility and reflexivity among service providers, since professionals who were involved in co-design reported improved work satisfaction and deeper engagement with their roles. This was also supported by Robert (2013) and Tollyfield (2014), who describe co-design as a mechanism for reconnecting professionals with the emotional and ethical dimensions of care.

The opportunity to participate was often associated with renewed hope and improved quality of life, which supports the notion that co-design, apart from shaping services, enables people who have been excluded from systems without the ability to exercise control to regain the agency which they rightly possess. Service User 1 expressed, *“It would be nice, even if not for myself, just to help others”*, while Service User 11 noted that he would participate in a co-design process *“because it could benefit me as well and I use it”*. This argument aligns with Batalden et al. (2016)’s assertion that reciprocal recognition in co-design can help promote dignity and empowerment.

For participants in this study, co-design was also framed as a potential site for mutual learning. Professional 1 articulated this as *“a learning process for everyone”*, and Manager 3 highlighted its collaborative strength, *“we play to each individual’s strengths for the good of the team and the service”*. This reflects the engagement and co-creation principles outlined in the Four Key Elements of Co-Design framework, as well as collaboration, shared responsibility, and building

the capacity for all people involved. It is only with the realisation of these principles that participation can move beyond tokenism to enable healing and structural repair.

Overall, this theme highlights that co-design can disrupt ingrained practices of marginalisation within mental health systems. As Trischler et al. (2019) assert, co-design repositions the target service users from the margins to the centre, guaranteeing maximum effectiveness as well as social equity. In this sense, co-design offers a potential shift up Arnstein's Ladder, from passive consultation to meaningful partnership. However, as this study shows, such movement is neither automatic nor guaranteed; it requires a deliberate reconfiguration of power structures that historically exclude lived expertise from decision-making authority.

This shift is also reflected in the words of Professional 5, who insisted that *"...something shifts when people are invited to participate because their voice matters. They start seeing themselves as architects of a system, not mere recipients"*, aligning with literature which refers to co-design as transformative, thus enabling individuals to transition from passive recipients to active collaborators (McKercher, 2020; Palmer et al., 2019; Pinfold et al., 2015). This transition positions service users as co-owners of the design and improvement process, thus challenging typical clinical hierarchies and rendering service user as co-owners of the design and improvement process (Beckett et al., 2018).

However, as Tindall et al. (2021) cautioned, empowerment within co-design can be fragile. This fragility was captured in Service User 10's doubt on *"whether my ideas would be implemented or not"*, signalling how easily a lack of feedback and implementation mechanism can invalidate the trust gained, by reintroducing disempowerment disguised as inclusion. As

Systems Theory reminds us, systems must be designed to allow this transition to move from inclusion to integration, from discourse to structure.

Literature documents the transformative nature of working together in co-design. Generating value enhances the self-worth of service user and enhances their sense of social belonging and inclusiveness (Batalden et al., 2016; Faulkner et al., 2021; Watson, 2022). Gillard et al. (2010), sets up tensions between more traditional identities, urging service users and professionals to meet in new ways of identifying and recognising one another.

In conclusion, this theme demonstrates that co-design can become empowering when systems enable it to be so. When enacted authentically, co-design can renew identities, rebuild trust and re-distribute power, but it requires structures that not only welcome participation but are also prepared to act on it. Only then can co-design serve as a method of improvement and a mode of repair.

However, for this to occur, stakeholders must be invited to contribute and empowered through systems designed to integrate that contribution. As Arnstein's Ladder depicts, efforts that remain at the consultation level, without redistributing influence, risk reinforcing the very inequalities co-design aims to dismantle.

5.3 Conclusion

The critical discussion of the five themes in this chapter has explored the complex realities of implementing co-design in Maltese mental health services. Each theme has shed light on different yet interconnected aspects: the value of lived experience, the emotional and relational foundations required for trust, the systemic and structural barriers that inhibit participation, the pivotal role of communication and a shared vision in determining success or failure, and the motivational drivers and perceived impact of co-design. Building on these thematic insights, the next section directly addresses the research questions of the study, by drawing on the critical points raised throughout the discussion.

5.4 Revisiting the Research Questions

Research Question 1:

What is the perspective of service users and healthcare professionals in relation to their inclusion and contribution to designing mental health services?

Both service users and healthcare professionals expressed strong enthusiasm for inclusion in the design of mental health services, based on a shared belief of the importance of lived experience and professional expertise. Upon critical reflection however, whilst enthusiasm for co-design exists at a superficial level, deeper systemic and emotional barriers undermine how empowered participants actually felt about contributing.

Service users repeatedly and consistently asserted a desire to contribute, derived from their lived experiences. They saw themselves as 'experts-by-experience, feeling that they would be able to contribute to the development of services by using their experiential knowledge of mental health issues. Their statements illustrate the vast reservoir of experiential insight that service users possess, which has yet to be tapped into. Healthcare professionals were largely in agreement, recognising the importance of tacit knowledge gained through frontline experience with service user, arguing that their work provides key insights, often missed by more distanced clinical or managerial vantage points.

However, despite this shared theoretical recognition, there is an evident gap between professional talk of inclusion and service user perceptions of inclusiveness. Whereas professionals discuss the contribution of service users as highly valued and wanted, service users report feeling ignored, undervalued or paternalistically managed, with several indicating that their suggestions have historically been ignored. Their experiences indicate that, while professionals may genuinely believe that they are open to service user input, service users do not experience this to be the case, suggesting deep-rooted mistrust, emotional disillusionment, and a sense of non-involvement which undermines the promise of genuine inclusion.

Similarly, healthcare professionals, while supportive in principle, indicated a lack of confidence in their voices being taken seriously within hierarchical organisation structures. On the other hand, they occasionally construct these issues as lying outside themselves, by blaming the 'system' or 'management', without fully recognising their own potential complicity in reproducing such barriers.

Furthermore, the findings indicate that emotional and psychological vulnerabilities, such as low self-esteem among service users and fear of being dismissed or judged, create significant barriers to effective participation. Professionals also recognised that trust-building and emotional safety were essential pre-conditions, yet findings suggest that these elements are often assumed rather than systematically nurtured.

In sum, while service users and professionals theoretically embrace the idea of inclusive co-design, both groups harbour deep-seated scepticism about whether existing systems and cultures are prepared to genuinely accommodate diverse contributions. Without structural

changes that explicitly address feelings of powerlessness, marginalisation, and distrust, the risk remains that co-design processes will fail to move beyond superficial consultation.

Research Question 2:

How does management view the inclusion of service users in the design of mental health services?

Managers in this study expressed largely positive perspectives of service user involvement in the design of mental health services, viewing it as both an organisational imperative and an ethical responsibility. However, critical triangulation with the perspectives of healthcare professionals reveals significant dissonance between managerial discourse and frontline reality. This gap raises fundamental questions about the depth of managerial commitment and the systemic barriers that jeopardise the implementation of co-design. A critical analysis of their accounts suggests that, while their support of co-design principles is sincere, there is a danger that the level of structural embeddedness and cultural transition required for authentic inclusion is underestimated.

Managers repeatedly asserted that service users have “first-hand information” necessary to develop person-centred services. One of the managers insisted that no professional could ever fully replace the insight a service user offers into their own needs, while another manager emphasised the creative potential of “diverse perspectives,” speculating that service users may suggested ideas that professionals would never envision. These claims echo contemporary co-design theory, which maintains that lived experience is a necessary source

of knowledge. In this sense, managers rightly challenged traditional professional hierarchies and validated the democratic principles underpinning co-design.

Moreover, managers made an ethical case for inclusion: they associated service user participation with empowerment, trust-building, and hope. One of the managers emphasised that the importance of building a bond of trust, while another argued that the very act of involving service users would ingrain service users with a sense of agency and future orientation. Here, managers demonstrated an awareness that inclusion is not merely instrumental (i.e., it leads to better services) but transformative: it has the potential to dignify those whose life experiences are often marginalising.

However, when critically cross-referenced with the perspectives of healthcare professionals, a more complex and less optimistic picture emerges. Professionals repeatedly pointed to management resistance to change, top-down decision making, and an entrenched dominant medical model that marginalises both their voices and those of service users. This starkly contradicts managerial claims about welcoming diverse perspectives and supporting empowerment through co-design.

Yet, against all this apparent openness, several tensions were also expressed, which deserve critical attention. First, while managers recognised the need for 'support networks' and 'structured approaches' to participation, their discourse often implied that the task of creating enabling structures would involve relatively minor calibration of existing systems: e.g. the appointment of a facilitator; selection of smaller meeting sizes. Yet systemic change involves more than simple logistical tweaks: there are fundamental questions to be asked of power,

professional roles and resource allocation. There was limited evidence that managers fully confronted the radical nature of these shifts.

Second, managers' recognition of barriers, including cognitive impairments or communication challenges experienced by service users, was sometimes liable to reinforce paternalistic assumptions. Two managers mentioned concerns about service users' 'lack of objectivity' and 'limited reflection abilities', implicitly invoking unsuitability as participants to co-design. These concerns are not without merit but reveal an underlying tension: while managers' rhetorical work aim to expand inclusion, there remains the possibility that managers may continue to resort to professional gatekeeping practices that delimit whose voices are ultimately heard in participatory processes. This was explicitly criticised by some professionals, stating that involvement is superficial and not ingrained into the organisation's belief, also identifying "inclusion" as a façade rather than true co-design.

Third, adopting existing professional structures, such as asking social workers or family members to support a service user to communicate their views, risks maintaining rather than challenging existing hierarchies. Having service user voices mediated by others who are already embedded within professional systems goes against the empowerment needed in co-design to enable service users to be equal partners in the process.

Finally, although managers pointed to systemic barriers such as bureaucracy and scarcity of resources, there was little evidence of critical questioning of their own institutions' resistance to change. For example, whilst one manager mentioned there being delays with decision making, the wider organisational cultures of privileging top-down control over participatory

innovation remained largely unchallenged. This suggests a possible gap between managers' ideals and the systemic inertia of many mental health services.

In conclusion, while managers in this study clearly identify and advocate the involvement of service users in the design of mental health services, their accounts reflect an optimistic yet rather uncritical conceptualisation of what meaningful inclusion requires. Their arguments clearly strongly support the rhetoric of co-design, though they appear to obscure the more fundamental structural, cultural and relational changes that would inevitably be needed for co-design to be seen as little more than rhetoric or tokenism.

The lived experiences of professionals suggest that this openness is often performative rather than transformative and expose a managerial culture that, while rhetorically committed to participation, remained fundamentally wedded to hierarchical structures, bureaucratic control and risk aversion.

This critical gap between managerial aspiration and organisational reality represents a significant barrier to the successful implementation of co-design, which needs to be addressed to fulfil the transformative potential of co-design.

Research Question 3:

What do service users and other stakeholders perceive as being the potential hindrances to an implementation of a co-design approach and do they believe it would be beneficial?

While all service users and other stakeholders broadly support the idea of co-design in principle, the findings reflect a highly complex terrain of structural, cultural and emotional barriers that radically endanger the implementation of co-design in practice. There is a critical disjunction between the theoretical attractiveness of co-design and the systemic inertia characterising Malta's mental health services.

First, trust and emotional safety emerge as essential preconditions for co-design, but also the most fragile. Service users reported profound concerns about judgment, tokenism, and being undervalued. For instance, one of the service users commented that sharing her lived experiences could lead to being harshly judged. Meanwhile, some professionals recognised that tokenism was a risk, warning that superficial inclusion undermines the assumption in co-design that empowerment involves participative parity.

A closely related point is the lack of trust in professionals and institutions, particularly among service users who have felt unheard or devalued in the past. Two managers acknowledge that trust must be carefully built over time, but this nurtured understanding stands in stark contrast to service users lived experiences, many of whom voiced deep mistrust that professionals would ever seriously take their views on board. The continuous mention of frustration, alongside the self-reported feelings of low esteem and powerlessness among service users,

indicates that, in the absence of deep culture change, participation stands the chance of being a more disempowering than empowering experience for service users.

Addressing longstanding professional power structures and paternalism is another significant barrier. Professionals were often highly critical of the ways in which power is wielded within mental health services, describing a top-down, medically dominated culture that is resistant to change. Some professionals explained how several voices, including those of service users and non-medical professionals, go unheard or are undervalued. Without addressing the foundational power dynamics, co-design in this regard stands the chance of being reduced to a superficial act of participation.

Additionally, these barriers are further entrenched due to societal discrimination towards mental health and self-stigma amongst service users. As both a service user and a manager reported, simply having service users present does not resolve the issue: the stigma that dominates mental illness, both institutionally and socially, can stifle expression, promote a sense of dread, and build an entrenched expectation of nothing appreciable changing.

Structural and systemic barriers further compromise the feasibility of co-design. Across all participant groups, people reported structural barriers such as bureaucracy, resource shortages, time constraints and organisational inertia as obstacles to co-design. Some professionals reported that mental health services are already under-resourced and overburdened, leaving little time or energy to engage in resource-intensive participatory processes. One of the managers also highlighted how even minor changes can be slowed down by bureaucratic inefficiencies, suggesting that meaningful co-design could become caught in red tape and stagnation. Closely linked to these concerns was the recurring theme

of inadequate funding. Several managers and professionals pointed to financial constraints as a core obstacle, arguing that without dedicated budgets, hiring additional staff or sustaining long-term co-design efforts would not be feasible. This financial limitation, apart from restricting human resources, also reflects a broader issue of how mental health is deprioritised when compared to physical health within the national agenda, which reveals a systemic undervaluing of participatory practice and the sectors in which they are meant to occur.

Another critical factor which is often neglected is the lack of financial recognition for the contributions of service users. Many health professionals reflected that, if the lived experience of service users is valued in co-design processes, they should be paid for their time, highlighting the injustice of expecting them to contribute valuable time and knowledge voluntarily, while healthcare professionals are being remunerated for their time, reinforcing existing inequalities.

Moreover, fragmented approaches, poor selection of participants, and rushed implementation efforts were identified as significant risk factors. As one professional pointed out, hurriedly placing service users into processes without adequate preparation risks both failure and harm. Participants highlighted the importance of having co-design carefully structured around the abilities, needs and preferences of participants; otherwise, participation would be superficial or exclusionary.

Despite these obstacles, a strong consensus remained among the participants in this study about the benefits of co-design, if implemented genuinely and systematically. Participants envisioned services that would be more person-centred, cost-effective and mutually beneficial, where service users would gain empowerment and dignity. Services would become

more responsive, flexible and effective. In the words of Professional 6: *“The person is not just a service user, you have a say, you have an opinion, and your opinion is valid”*. Yet, the overwhelming feeling was that this ideal outcome could not come about automatically, but would require radical cultural change, institutional support, and constant vigilance to counter tokenism and co-optation.

In conclusion, while co-design is commonly considered a very desirable reform, its implementation in practice is fraught with risks rooted in systemic mistrust, professional hierarchies, structural barriers and societal stigma. Unless these barriers are directly targeted and dismantled, co-design has the potential to remain aspirational rather than transformational, a well-intentioned concept that fails to deliver on its emancipatory promise.

CHAPTER 6: CONCLUSION

6.1 Summary of the research study

This study critically explored the perceptions of participants on stakeholders' involvement in co-designing services as well as the perceived benefits and potential hindrances of implementing co-design within the mental health services in Malta, a context where participatory approaches remain underdeveloped. Guided by an interpretivist paradigm and a qualitative case study design, the study exposed how rhetorical support for co-design often collapses under systemic inertia, bureaucratic rigidity, and resource scarcity.

Unlike most of the existing literature, which focuses on perceptions gathered after co-design implementation, this study captured rarely documented pre-implementation insights into the barriers, anxieties and emotional vulnerabilities that shape participants' readiness for this work. Through the triangulated analysis from the perspectives of service users, healthcare professionals and managers, this study indicates the fragility of a system still not ready to move from tokenistic consultation to genuine participation without substantial structural and cultural reform.

6.2 Practical Implications

The study highlights several immediate practical implications:

- **The Need for Structural Change:** Co-design will remain a rhetoric aspiration, unless longstanding bureaucratic inefficiencies, hierarchical silos and perpetual underfunding are addressed, to turn it into an operational reality.
- **Prioritising Emotional Safety:** It is essential for co-design initiatives to consider the emotional needs of its participants, building on authentic relational trust to avoid delving into superficial engagement, which would further alienate service users, deepening their trauma and harm.
- **Preparation, Not Assumption:** Service users and professionals need to be prepared to meet the demands and relational challenges brought about by co-design.
- **Financial Recognition:** Remuneration of experts by experience for their contribution to co-design initiatives needs to be in place, thereby mitigating exploitative practices which make these service users feel undervalued.
- **Senior Leadership Commitment:** Without genuine support from management, coupled with a true understanding of the requirements for co-design implementation, initiatives will be vulnerable to bureaucratic stagnation and tokenism.

In sum, meaningful co-design requires proactively re-engineering organisation culture.

6.3 Strengths and limitations of the study

6.3.1 Strengths

- **Contextual and Temporal Originality:** This study provides rare and timely insights into the earliest barriers to co-design by exploring pre-implementation perspectives in an under-explored national context.
- **Triangulated Stakeholder Perspectives:** Through the incorporation of different stakeholders, this study obtained a multidimensional view on the systemic barriers and emotional costs that the participants perceive as predeterminants to co-design success.
- **Focus on Emotional Impact:** Beyond structural critique, the study highlights psychological vulnerability as being a critical determinant of successful participation.

6.3.2 Limitations

- **Temporal Limitations:** The study attempts to capture a cross-sectional 'snapshot' of co-design perceptions. It is not equipped to capture changing perceptions over time as participants gain more experience of actual co-design in practice.
- **Context-Specificity:** Findings are heavily contextualised within the Maltese mental health system and must be interpreted with caution when extrapolating them to other contexts.

- **Recruitment/Participant Representation:** Although this evaluation has tried to capture a diversity of voices, the perspectives of highly marginalised service users remain somewhat underrepresented.
- **Interpretive Nature:** The qualitative methodology favours depth over breadth, highlighting that findings reflect the constructed realities rather than generalisable facts. As for all qualitative research, the interpretive lens of the researcher is influential within this study. Whilst efforts were made to approach the data in a systematic and transparent way, this study acknowledges that the process of thematic analysis, particularly the interpretation of subjective experiences, allows an inherent risk of researcher bias. The meanings constructed from participant narratives are influenced by the researcher's own perspectives, assumptions, and positionality. Although reflexive practices, such as repeated coding checks, were employed to mitigate this, the findings must still be understood as co-constructed interpretations rather than objective truths. This limitation is intrinsic to qualitative inquiry and reflects the epistemological stance of the study, which prioritises depth, context, and meaning over generalisability.

6.4 Recommendations for Future Research

Future research should pursue:

- **Longitudinal Inquiry:** Mapping shifts in engagement, resilience and responsiveness to the system by tracking stakeholders across pre-, during-, and post-co-design phases.

- **Interventional Studies:** Testing frameworks and capacity building models which explicitly address structural barriers, emotional safety and redistribution of power.
- **Cross-national Comparative Research:** Understanding how systems with different levels of participatory maturity deal with cultural, historical and institutional barriers.
- **Economic Analysis:** Exploring economic models necessary to make real co-design feasible, especially in resource-constrained settings.
- **Focused Power Dynamics Exploration:** Understanding how trauma, hierarchy, and relational distrust exist in early-stage co-design projects, and ways these can be mitigated.
- **Mixed-method research:** Complementing the qualitative insights of this study with measurable outcomes, offering a more holistic understanding of co-design's impact within Maltese mental health services.

6.5 Conclusion

Ultimately, this study underscores the importance of systemic transformation, beyond well-meaning and well-intentioned rhetoric. Without this transformation, system practices and processes of co-design risk becoming a hollow exercise that further alienates those it seeks to empower. Meaningful system transformation demands an ethical, emotional, and structural reorientation of mental health systems towards equity, dignity and shared authority.

This study highlights that there may be numerous barriers to the implementation of co-design in Malta. Whilst managers and professionals express a genuine interest in the concept, their

understanding of the systemic transformation, which is required to reach successful outcomes, is somewhat restricted. Some services users could understand how this could potentially lead to better services, however, they all expressed that before delving into a co-design implementation or any other self-actualising need, they would rather have their basic and psychological needs met. This could mean that, in selecting co-design participants, it would be best to identify service users who have reached a psychological state that ensures that the process will not affect them negatively. It also serves as a stark reminder that it might be better to use co-design initiatives to improve on the current services, and deal with the current needs of the service users rather than to introduce new services. This should result in the service users becoming more receptive, and improving the trust relationship between, management, professionals, and service users.

References

- Albert, A., Islam, S., Haklay, M., & McEachan, R. R. C. (2023). Nothing about us without us: A co-production strategy for communities, researchers and stakeholders to identify ways of improving health and reducing inequalities. *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy*, 26(2), 836–846. <https://doi.org/10.1111/hex.13709>
- Armstrong, N., Herbert, G., Aveling, E., Dixon-Woods, M., & Martin, G. (2013). Optimizing patient involvement in quality improvement. *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy*, 16(3), e36–e47. <https://doi.org/10.1111/hex.12039>
- Arnstein, S. R. (1969). A Ladder Of Citizen Participation. *Journal of the American Institute of Planners*, 35(4), 216–224. <https://doi.org/10.1080/01944366908977225>
- Bailey, C. A. (2008). *A guide to qualitative field research* (2nd ed.). Pine Forge Press.
- Batalden, M., Batalden, P., Margolis, P., Seid, M., Armstrong, G., Opipari-Arrigan, L., & Hartung, H. (2016). Coproduction of healthcare service. *BMJ Quality & Safety*, 25(7), 509–517. <https://doi.org/10.1136/bmjqs-2015-004315>
- Bate P, Robert G (2006). Experience-based design: from redesigning the system around the patient to co-designing services with the patient. *Qual Saf Health Care*, 15(5):307–10. <https://doi: 10.1136/qshc.2005.016527>
- Bate, P. & Robert, G. (2007). Towards more user-centric OD: Lessons from the field of experience-based design and a case study. *The Journal of Applied Behavioural Science*, 43, 41–66
- Beckett, K., Farr, M., Kothari, A., Wye, L., & le May, A. (2018). Embracing complexity and uncertainty to create impact: exploring the processes and transformative potential of co-produced research through development of a social impact model. *Health Research Policy and Systems*, 16(1), 118–118. <https://doi.org/10.1186/s12961-018-0375-0>
- Beecroft, B., Sturke, R., Neta, G., & Ramaswamy, R. (2022). The “case” for case studies: why we need high-quality examples of global implementation research. *Implementation Science Communications*, 3(1), 15–15. <https://doi.org/10.1186/s43058-021-00227-5>
- Beresford, P. (2013). From ‘other’ to involved: user involvement in research: an emerging paradigm. *Nordic Social Work Research*, 3(2), 139–148. <https://doi.org/10.1080/2156857X.2013.835138>
- Bird, M., Ouellette, C., Whitmore, C., Li, L., Nair, K., McGillion, M. H., Yost, J., Banfield, L., Campbell, E., & Carroll, S. L. (2020). Preparing for patient partnership: A scoping review of patient partner engagement and evaluation in research. *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy*, 23(3), 523–539. <https://doi.org/10.1111/hex.13040>

- Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: A tool to enhance trustworthiness or merely a nod to validation? *Qualitative Health Research, 26*(13), 1802–1811. <https://doi.org/10.1177/1049732316654870>
- Blickem, C., Kennedy, A., Vassilev, I., Morris, R., Brooks, H., Jariwala, P., Blakeman, T., & Rogers, A. (2013). Linking people with long-term health conditions to healthy community activities: development of Patient-Led Assessment for Network Support (PLANS). *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy, 16*(3), e48–e59. <https://doi.org/10.1111/hex.12088>
- Blomkamp, E. (2018). The promise of co-design for public policy. *Australian Journal of Public Administration, 77*(4), 729–743. <https://doi.org/10.1111/1467-8500.12310>
- Boaz, A., Biri, D., & McKeivitt, C. (2016). Rethinking the relationship between science and society: Has there been a shift in attitudes to Patient and Public Involvement and Public Engagement in Science in the United Kingdom? *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy, 19*(3), 592–601. <https://doi.org/10.1111/hex.12295>
- Bombard, Y., Baker, G. R., Orlando, E., Fancott, C., Bhatia, P., Casalino, S., Onate, K., Denis, J.-L., & Pomey, M.-P. (2018). Engaging patients to improve quality of care: a systematic review. *Implementation Science: IS, 13*(1), 98–98. <https://doi.org/10.1186/s13012-018-0784-z>
- Booth, A., Sutton, A., & Papaioannou, D. (2016). *Systematic approaches to a successful literature review* (2nd ed.). SAGE Publications.
- Bosak, J., Drainoni, M., Bryer, C., Goodman, D., Messersmith, L., & Declercq, E. (2024). ‘It opened my eyes, my ears, and my heart’: Codesigning a substance use disorder treatment programme. *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy, 27*(1), e13908-n/a. <https://doi.org/10.1111/hex.13908>
- Bowen, S., Dearden, A., Wolstenholme, D., Cobb, M., & Wright, P. (2010). Co-designing better outpatient services for older people: Inspiration stories for participatory design with health and social care institutions workshop, PDC 2010. Retrieved from <http://www.uchd.org.uk/wpcontent/uploads/2010/09/PDCworkshopStoriesUCHD.pdf>
- Bowen, S., McSeveny, K., Lockley, E., Wolstenholme, D., Cobb, M., & Dearden, A. (2013). How was it for you? Experiences of participatory design in the UK health service. *CoDesign, 9*(4), 230–246. <https://doi.org/10.1080/15710882.2013.846384>
- Brett, J., Staniszewska, S., Mockford, C., Herron-Marx, S., Hughes, J., Tysall, C., & Suleman, R. (2014). A Systematic Review of the Impact of Patient and Public Involvement on Service Users, Researchers and Communities. *The Patient : Patient-Centered Outcomes Research, 7*(4), 387–395. <https://doi.org/10.1007/s40271-014-0065-0>
- Brown T, Wyatt J. (2010). Design Thinking for Social Innovation. *Development Outreach, 12*(1):29–43. https://doi: 10.1596/1020-797x_12_1_29.

- Burkitt, I. (1996). [Rev. of *An Introduction to Social Constructionism*]. *The British Journal of Sociology*, 47(4), 718–720. <https://doi.org/10.2307/591084>
- Byrne, L., & Wykes, T. (2020). A role for lived experience mental health leadership in the age of Covid-19. *Journal of Mental Health (Abingdon, England)*, 29(3), 243–246. <https://doi.org/10.1080/09638237.2020.1766002>
- Chauhan, A., Walpola, R. L., Manias, E., Seale, H., Walton, M., Wilson, C., Smith, A. B., Li, J., & Harrison, R. (2021). How do health services engage culturally and linguistically diverse consumers? An analysis of consumer engagement frameworks in Australia. *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy*, 24(5), 1747–1762. <https://doi.org/10.1111/hex.13315>
- Cherns, A. (1976). The principles of sociotechnical design. *Human Relations*, 29(8), 783–792. <https://doi.org/10.1177/001872677602900806>
- Chesterman, D., & Bray, M. (2018). Report on some action research in the implementation of social prescription in Crawley. Paths to greater wellbeing: “sometimes you have to be in it to get it.” *Action Learning*, 15(2), 168–181. <https://doi.org/10.1080/14767333.2018.1467302>
- Chisholm, L., Holttum, S., & Springham, N. (2018). Processes in an Experience-Based Co-Design Project With Family Carers in Community Mental Health. *SAGE Open*, 8(4). <https://doi.org/10.1177/2158244018809220>
- Claes, C., Van Hove, G., Vandeveld, S., van Loon, J., & Schalock, R. L. (2010). Person-Centered Planning: Analysis of Research and Effectiveness. *Intellectual and Developmental Disabilities*, 48(6), 432–453. <https://doi.org/10.1352/1934-9556-48.6.432>
- Clarke, D., Jones, F., Harris, R., & Robert, G. (2017). What outcomes are associated with developing and implementing co-produced interventions in acute healthcare settings? A rapid evidence synthesis. *BMJ Open*, 7(7), e014650–e014650. <https://doi.org/10.1136/bmjopen-2016-014650>
- Cooper K, Gillmore C, Hogg L. Experience-based co-design in an adult psychological therapies service. *J Ment Health*. 2015;25(1):36-40. <https://doi.org/10.3109/09638237.2015.1101423>.
- Cooper, Marion; Cornish, Peter ; Berry, Gillian. Stubborn Hierarchies: The Challenges of Co-design. *Stepped Care 2.0: The Power of Conundrums*, 2023, p.229-241. https://doi.org/10.1007/978-3-031-45206-2_14
- Coulter, A., Locock, L., Ziebland, S., & Calabrese, J. (2014). Collecting data on patient experience is not enough: they must be used to improve care. *BMJ (Online)*, 348(mar26 1), g2225–g2225. <https://doi.org/10.1136/bmj.g2225>
- Cox, R., Molineux, M., Kendall, M., Tanner, B., & Miller, E. (2022). Co-produced capability framework for successful patient and staff partnerships in healthcare quality improvement: results of a scoping review. *BMJ Quality & Safety*, 31(2), 134–146. <https://doi.org/10.1136/bmjqs-2020-012729>

Cree, L., Brooks, H. L., Berzins, K., Fraser, C., Lovell, K., & Bee, P. (2015). Carers' experiences of involvement in care planning: a qualitative exploration of the facilitators and barriers to engagement with mental health services. *BMC Psychiatry*, *15*(1), 208–208. <https://doi.org/10.1186/s12888-015-0590-y>

Creswell, J. W. (2012). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research* (4th ed.). Pearson Education.

Creswell, J. W. (2015). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research* (5th ed.). Pearson Education.

Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). SAGE Publications.

Crowe, S., Cresswell, K., Robertson, A., Huby, G., Avery, A., & Sheikh, A. (2011). The case study approach. *BMC Medical Research Methodology*, *11*(1), 100–100. <https://doi.org/10.1186/1471-2288-11-100>

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2011). *The SAGE handbook of qualitative research* (4th ed.). SAGE Publications.

Dilthey, W. (1991). *Introduction to the human sciences* (R. A. Makkreel & F. Rodi, Eds. & Trans.). Princeton University Press. (Original work published 1883)

Dixon-Woods, M. (2011). Using framework-based synthesis for conducting reviews of qualitative studies. *BMC Medicine*, *9*(1), 39–39. <https://doi.org/10.1186/1741-7015-9-39>

Donetto, S., Pierrri, P., Tsianakas, V., & Robert, G. (2015). Experience-based Co-design and Healthcare Improvement: Realizing Participatory Design in the Public Sector. *The Design Journal*, *18*(2), 227–248. <https://doi.org/10.2752/175630615X14212498964312>

Dudau, A., Glennon, R., & Verschuere, B. (2019). Following the yellow brick road? (Dis)enchantment with co-design, co-production and value co-creation in public services. *Public Management Review*, *21*(11), 1577–1594. <https://doi.org/10.1080/14719037.2019.1653604>

Dunston, R., Lee, A., Boud, D., Brodie, P., & Chiarella, M. (2009). Co-Production and Health System Reform - From Re-Imagining To Re-Making. *Australian Journal of Public Administration*, *68*(1), 39–52. <https://doi.org/10.1111/j.1467-8500.2008.00608.x>

Ezaydi, N., Sheldon, E., Kenny, A., Buck, E. T., & Weich, S. (2023). Service user involvement in mental health service commissioning, development and delivery: A systematic review of service level outcomes. *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy*, *26*(4), 1453–1466. <https://doi.org/10.1111/hex.13788>

Farone, D. W. (2006). Schizophrenia, Community Integration, and Recovery: Implications for Social Work Practice. *Social Work in Mental Health*, *4*(4), 21–36. https://doi.org/10.1300/J200v04n04_02

- Farr, M. (2018). Power dynamics and collaborative mechanisms in co-production and co-design processes. *Critical Social Policy*, 38(4), 623–644. <https://doi.org/10.1177/0261018317747444>
- Faulkner, A., Carr, S., Gould, D., Khisa, C., Hafford-Letchfield, T., Cohen, R., Megele, C., & Holley, J. (2021). 'Dignity and respect': An example of service user leadership and co-production in mental health research. *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy*, 24(S1), 10–19. <https://doi.org/10.1111/hex.12963>
- Flyvbjerg, B. (2006). Five Misunderstandings About Case-Study Research. *Qualitative Inquiry*, 12(2), 219–245. <https://doi.org/10.1177/1077800405284363>
- Gartshore, A. S. (2018). *Testing experience based co design: understanding patient and staff experience of experience based co design on an acute mental health ward to promote patient centred service improvement : a multiple methods study*. ProQuest Dissertations & Theses.
- Gillard, S., Turner, K., Lovell, K., Norton, K., Clarke, T., Addicott, R., McGivern, G., & Ferlie, E. (2010). "Staying native": coproduction in mental health services research. *The International Journal of Public Sector Management*, 23(6), 567–577. <https://doi.org/10.1108/09513551011069031>
- Gordon, S., & O'Brien, A. J. (2018). Co-production: Power, problems and possibilities. *International Journal of Mental Health Nursing*, 27(4), 1201–1203. <https://doi.org/10.1111/inm.12504>
- Griffin, S. J. (2004). Effect on Health-Related Outcomes of Interventions to Alter the Interaction Between Patients and Practitioners: A Systematic Review of Trials. *Annals of Family Medicine*, 2(6), 595–608. <https://doi.org/10.1370/afm.142>
- Guba, E. G., & Lincoln, Y. S. (1985). *Naturalistic inquiry*. SAGE Publications.
- Habermas, J. (1984). *The Theory of Communicative Action*. Beacon Press.
- Hall, T., Loveday, S., Pullen, S., Loftus, H., Constable, L., Paton, K., & Hiscock, H. (2023). Co-designing an Integrated Health and Social Care Hub With and for Families Experiencing Adversity. *International Journal of Integrated Care*, 23(2), 3–3. <https://doi.org/10.5334/ijic.6975>
- Happell, B., Platania-Phung, C., Byrne, L., Wynaden, D., Martin, G., & Harris, S. (2015). Consumer participation in nurse education: A national survey of Australian universities. *International Journal of Mental Health Nursing*, 24(2), 95–103. <https://doi.org/10.1111/inm.12111>
- Hassan, S. M., Giebel, C., Morasae, E. K., Rotheram, C., Mathieson, V., Ward, D., Reynolds, V., Price, A., Bristow, K., & Kullu, C. (2020). Social prescribing for people with mental health needs living in disadvantaged communities: the Life Rooms model. *BMC Health Services Research*, 20(1), 1–9. <https://doi.org/10.1186/s12913-019-4882-7>

- Heerings, M., van de Bovenkamp, H., Cardol, M., & Bal, R. (2020). Ethical Dilemmas of Participation of Service Users with Serious Mental Illness: A Thematic Synthesis. *Issues in Mental Health Nursing, 41*(4), 283–295. <https://doi.org/10.1080/01612840.2019.1667459>
- Heerings, M., van de Bovenkamp, H., Cardol, M., & Bal, R. (2022). Tinkering as Collective Practice: A Qualitative Study on Handling Ethical Tensions in Supporting People with Intellectual or Psychiatric Disabilities. *Ethics and Social Welfare, 16*(1), 36–53. <https://doi.org/10.1080/17496535.2021.1954223>
- Henderson C, Noblett J, Parke H, Clement S, Caffrey A, Gale-Grant O, Schulze B, Druss B, Thornicroft G. (2014). Mental health-related stigma in health care and mental health-care settings. *Lancet Psychiatry. 2014 Nov;1*(6):467-82. [https://doi: 10.1016/S2215-0366\(14\)00023-6](https://doi: 10.1016/S2215-0366(14)00023-6).
- Heslop, L., Cranwell, K., & Burton, T. (2019). Care coordination for chronic and complex health conditions: An experienced based co-design study engaging consumer and clinician groups for service improvement. *PloS One, 14*(10), e0224380–e0224380. <https://doi.org/10.1371/journal.pone.0224380>
- Higgins, J. P. T., Altman, D. G., Gøtzsche, P. C., Jüni, P., Moher, D., Oxman, A. D., Savović, J., Schulz, K. F., Weeks, L., & Sterne, J. A. C. (2011). The Cochrane Collaboration’s tool for assessing risk of bias in randomised trials. *BMJ, 343*(7829), 889–893. <https://doi.org/10.1136/bmj.d5928>
- Horkheimer, M. (1972). *Critical theory: Selected essays* (M. O’Connell, Trans.). Herder and Herder. (Original work published 1937)
- Iedema, R., Merrick, E., Piper, D., Britton, K., Gray, J., Verma, R., Manning, N., Oswick, C., Marshak, R. J., Wolfram-Cox, J., & Grant, D. (2010). Codesigning as a Discursive Practice in Emergency Health Services: The Architecture of Deliberation. *The Journal of Applied Behavioral Science, 46*(1), 73–91. <https://doi.org/10.1177/0021886309357544>
- Illarregi, E. R., Alexiou, K., DiMalta, G., & Zamenopoulos, T. (2023). Is designing therapeutic? A case study exploring the experience of co-design and psychosis. *Psychosis, 15*(3), 277–291. <https://doi.org/10.1080/17522439.2022.2052450>
- Illback, R. J., Bates, T., Hodges, C., Galligan, K., Smith, P., Sanders, D., & Dooley, B. (2010). Jigsaw: Engaging communities in the development and implementation of youth mental health services and supports in the Republic of Ireland. *Journal of Mental Health (Abingdon, England), 19*(5), 422–435. <https://doi.org/10.3109/09638231003728141>
- Israel, M. (2015). Avoiding harm, doing good and seeking justice. In *Avoiding harm, doing good and seeking justice* (2 ed., pp. 123-146). SAGE Publications Ltd. <https://doi.org/10.4135/9781473910096.n7>
- Jones, M., & Pietilä, I. (2020). Personal perspectives on patient and public involvement – stories about becoming and being an expert by experience. *Sociology of Health & Illness, 42*(4), 809–824. <https://doi.org/10.1111/1467-9566.13064>

- Kehoe, M., Whitehead, R., Boer, K., Meyer, D., Hopkins, L., & Nedeljkovic, M. (2024). A qualitative evaluation of a co-design process involving young people at risk of suicide. *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy*, 27(1), e13986-n/a. <https://doi.org/10.1111/hex.13986>
- Khan, K. S., Kunz, R., Kleijnen, J., & Antes, G. (2003). Five Steps to Conducting a Systematic Review. *Journal of the Royal Society of Medicine*, 96(3), 118–121. <https://doi.org/10.1177/014107680309600304>
- Knaak, S., Mantler, E., & Szeto, A. (2017). [Rev. of *Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions*]. *Healthcare Management Forum*, 30(2), 111–116. <https://doi.org/10.1177/0840470416679413>
- Larkin, M., Boden, Z. V. R., & Newton, E. (2015). On the Brink of Genuinely Collaborative Care: Experience-Based Co-Design in Mental Health. *Qualitative Health Research*, 25(11), 1463–1476. <https://doi.org/10.1177/1049732315576494>
- Liamputtong, P. (2009). Qualitative Data Analysis: Conceptual and Practical Considerations. *Health Promotion Journal of Australia*, 20(2), 133–139. <https://doi.org/10.1071/HE09133>
- Lincoln, Y.S. (1995) Emerging Criteria for Quality in Qualitative and Interpretive Research. *Qualitative Inquiry*, 1, 275–289. <http://dx.doi.org/10.1177/107780049500100301>
- Locock, L., Robert, G., Boaz, A., Vougioukalou, S., Shuldham, C., Fielden, J., Ziebland, S., Gager, M., Tollyfield, R., & Pearcey, J. (2014). Using a national archive of patient experience narratives to promote local patient-centered quality improvement: an ethnographic process evaluation of “accelerated” experience-based co-design. *Journal of Health Services Research & Policy*, 19(4), 200–207. <https://doi.org/10.1177/1355819614531565>
- Lwembe, S., Green, S. A., Chigwende, J., Ojwang, T., & Dennis, R. (2017). Co-production as an approach to developing stakeholder partnerships to reduce mental health inequalities: an evaluation of a pilot service. *Primary Health Care Research & Development*, 18(1), 14–23. <https://doi.org/10.1017/S1463423616000141>
- Lyon, A. R., & Koerner, K. (2016). User-centered design for psychosocial intervention development and implementation. *Clinical Psychology: Science and Practice*, 23(2), 180–200. <https://doi.org.ejournals.um.edu/10.1111/cpsp.12154>
- MacQueen, K. M., McLellan, E., Kay, K., & Milstein, B. (2008). Codebook development for team-based qualitative analysis. In G. Guest & K. M. MacQueen (Eds.), *Handbook for team-based qualitative research* (pp. 119–135). AltaMira Press
- McAllister, S., Simpson, A., Tsianakas, V., Canham, N., De Meo, V., Stone, C., & Robert, G. (2021). Developing a theory-informed complex intervention to improve nurse–patient therapeutic engagement employing Experience-based Co-design and the Behaviour Change Wheel: an acute mental health ward case study. *BMJ Open*, 11(5), e047114-. <https://doi.org/10.1136/bmjopen-2020-047114>

- McCutcheon, D. M., & Meredith, J. R. (1993). Conducting case study research in operations management. *Journal of Operations Management*, 11(3), 239–256. [https://doi.org/10.1016/0272-6963\(93\)90002-7](https://doi.org/10.1016/0272-6963(93)90002-7)
- McEvoy, P. M., Horgan, B., Eadon, O. L., Yong, M. J., Soraine, J., & Chiu, V. W. (2023). Development of a research capacity and culture tool for people with lived experience of mental health challenges. *Australian and New Zealand Journal of Psychiatry*, 57(6), 865–874. <https://doi.org/10.1177/00048674221125597>
- McGowan, D., Morley, C., Hansen, E., Shaw, K., & Winzenberg, T. (2024). Experiences of participants in the co-design of a community-based health service for people with high healthcare service use. *BMC Health Services Research*, 24(1), 339–339. <https://doi.org/10.1186/s12913-024-10788-5>
- McKercher KA. (2020). *Beyond sticky notes: Co-design for Real: Mindsets, Methods and Movements*. Beyond Stick Notes, 2020
- Meadows, D. H. (2008). *Thinking in systems: A primer* (D. Wright, Ed.). Chelsea Green Publishing.
- Mills, A. J., Durepos, G., & Wiebe, E. (Eds.). (2010). *Encyclopedia of case study research* (Vols. 1–2). SAGE Publications.
- Minogue, V., Boness, J., Brown, A., & Girdlestone, J. (2005). The impact of service user involvement in research. *International Journal of Health Care Quality Assurance*, 18(2), 103–112. <https://doi.org/10.1108/09526860510588133>
- Mockford, C., Staniszewska, S., Griffiths, F., & Herron-Marx, S. (2012). The impact of patient and public involvement on UK NHS health care: a systematic review. *International Journal for Quality in Health Care*, 24(1), 28–38. <https://doi.org/10.1093/intqhc/mzr066>
- Modigh, A., Sampaio, F., Moberg, L., & Fredriksson, M. (2021). The impact of patient and public involvement in health research versus healthcare: a scoping review of reviews. *Health Policy (Amsterdam)*, 125(9), 1208–1221. <https://doi.org/10.1016/j.healthpol.2021.07.008>
- Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & Group, T. P. (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement: e1000097. *PLoS Medicine*, 6(7). <https://doi.org/10.1371/journal.pmed.1000097>
- Moll, S., Wyndham-West, M., Mulvale, G., Park, S., Buettgen, A., Phoenix, M., Fleisig, R., & Bruce, E. (2020). [Rev. of *Are you really doing 'codesign'? Critical reflections when working with vulnerable populations*]. *BMJ Open*, 10(11), e038339–e038339. <https://doi.org/10.1136/bmjopen-2020-038339>
- Muir, C., Kedzior, S. G. E., Barrett, S., McGovern, R., Kaner, E., Wolfe, I., & Forman, J. R. (2024). Co-design workshops with families experiencing multiple and interacting adversities including parental mental health, substance use, domestic violence, and poverty: intervention principles and insights from mothers, fathers, and young people. *Research Involvement and Engagement*, 10(1), 67–16. <https://doi.org/10.1186/s40900-024-00584-0>

- Mulvale, A., Miatello, A., Hackett, C., & Mulvale, G. (2016). Applying experience-based co-design with vulnerable populations: Lessons from a systematic review of methods to involve patients, families and service providers in child and youth mental health service improvement. *Patient Experience Journal*, 3(1), 117–129. <https://doi.org/10.35680/2372-0247.1104>
- Mulvale, G., Moll, S., Miatello, A., Murray-Leung, L., Rogerson, K., & Sassi, R. B. (2019). Co-designing Services for Youth With Mental Health Issues: Novel Elicitation Approaches. *International Journal of Qualitative Methods*, 18. <https://doi.org/10.1177/1609406918816244>
- Mulvale, G., Moll, S., Phoenix, M., Buettgen, A., Freeman, B., Murray-Leung, L., Micsinszki, S. K., Mulalu, L., Vrzovski, A., & Foisy, C. (2024). Co-creating a new Charter for equitable and inclusive co-creation: insights from an international forum of academic and lived experience experts. *BMJ Open*, 14(3), e078950-. <https://doi.org/10.1136/bmjopen-2023-078950>
- Namey, E., Guest, G., Thairu, L., & Johnson, L. (2008). Data reduction techniques for large qualitative data sets. In G. Guest & K. M. MacQueen (Eds.), *Handbook for team-based qualitative research* (pp. 137–161). AltaMira Press.
- Nguyen, A. J., Rykiel, N., Murray, L., Amin, A., Haroz, E., Lee, C., & Bolton, P. (2019). Stakeholder perspectives on integration of mental health services into primary care: a mixed methods study in Northern Iraq. *International Journal of Mental Health Systems*, 13(1), 75–75. <https://doi.org/10.1186/s13033-019-0330-7>
- Ní Shé, É., Davies, C., Blake, C., Crowley, R., McCann, A., Fullen, B., O'Donnell, D., O'Connor, J., Kelly, S., Darcy, M., Bolger, F., Ziebland, S., Taylor, M., Watt, P., O'Sullivan, D., Day, M., Mitchell, D., Donnelly, S., McAuliffe, E., ... Kroll, T. (2018). What are the mechanisms that enable the reciprocal involvement of seldom heard groups in health and social care research? A rapid realist review protocol. *HRB Open Research*, 1, 7-. <https://doi.org/10.12688/hrbopenres.12790.1>
- Ní Shé, É., Morton, S., Lambert, V., Ní Cheallaigh, C., Lacey, V., Dunn, E., Loughnane, C., O'Connor, J., McCann, A., Adshead, M., & Kroll, T. (2019). Clarifying the mechanisms and resources that enable the reciprocal involvement of seldom heard groups in health and social care research: A collaborative rapid realist review process. *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy*, 22(3), 298–306. <https://doi.org/10.1111/hex.12865>
- National Institute for Health and Care Excellence (NICE). (2016). *Transition from children's to adults' services for young people using health or social care services* (NICE Guideline No. NG43). <https://www.nice.org.uk/guidance/ng43>
- O'Brien, J., Fossey, E., & Palmer, V. J. (2021). A scoping review of the use of co-design methods with culturally and linguistically diverse communities to improve or adapt mental health services. *Health & Social Care in the Community*, 29(1), 1–17. <https://doi.org/10.1111/hsc.13105>

O’Keeffe, L., O’Reilly, A., O’Brien, G., Buckley, R., & Illback, R. (2015). Description and outcome evaluation of Jigsaw: an emergent Irish mental health early intervention programme for young people. *Irish Journal of Psychological Medicine*, 32(1), 71–77. <https://doi.org/10.1017/ipm.2014.86>

O’Mara-Eves, A., Brunton, G., McDaid, D., Oliver, S., Kavanagh, J., Jamal, F., Matosevic, T., Harden, A., & Thomas, J. (2013). Community engagement to reduce inequalities in health: a systematic review, meta-analysis and economic analysis. *Public Health Research (Southampton, England)*, 1(4), 1–526. <https://doi.org/10.3310/phr01040>

O’Reilly, A., O’Brien, G., Moore, J., Duffy, J., Longmore, P., Cullinan, S., & McGrory, S. (2022). Evolution of Jigsaw - a National Youth Mental Health Service. *Early Intervention in Psychiatry*, 16(5), 561–567. <https://doi.org/10.1111/eip.13218>

Ocloo, J., & Matthews, R. (2016). From tokenism to empowerment: progressing patient and public involvement in healthcare improvement. *BMJ Quality & Safety*, 25(8), 626–632. <https://doi.org/10.1136/bmjqs-2015-004839>

Ocloo, J., Goodrich, J., Tanaka, H., Birchall-Searle, J., Dawson, D., & Farr, M. (2020). The importance of power, context and agency in improving patient experience through a patient and family centred care approach. *Health Research Policy and Systems*, 18(1), 10–10. <https://doi.org/10.1186/s12961-019-0487-1>

Ocloo, J., Garfield, S., Franklin, B. D., & Dawson, S. (2021). Exploring the theory, barriers and enablers for patient and public involvement across health, social care and patient safety: a systematic review of reviews. *Health Research Policy and Systems*, 19(1), 8–8. <https://doi.org/10.1186/s12961-020-00644-3>

Odejimi, O., Lang, L., & Serrant, L. (2021). Optimising service users and carers involvement in nursing and social work pre-registration degrees. *Nurse Education Today*, 107, 105128–105128. <https://doi.org/10.1016/j.nedt.2021.105128>

Office of the Deputy Prime Minister, Building Resilience, Transforming Services. A Mental Health Strategy for Malta 2020-2030 15–15 (2018).

Oliver, K., Kothari, A., & Mays, N. (2019). The dark side of coproduction: do the costs outweigh the benefits for health research? *Health Research Policy and Systems*, 17(1), 33–33. <https://doi.org/10.1186/s12961-019-0432-3>

Olson, K., Young, R. A., Schultz, I. Z., Schultz, I. Z., & Young, R. A. (2015). *Handbook of Qualitative Health Research for Evidence-Based Practice* (1st ed. 2016, Vol. 4). Springer. <https://doi.org/10.1007/978-1-4939-2920-7>

Onie, S., Berlinquette, P., Holland, S., Livingstone, N., Finemore, C., Gale, N., Elder, E., Laggis, G., Heffernan, C., Armstrong, S. O., Theobald, A., Josifovski, N., Torok, M., Shand, F., & Larsen, M. (2023). Suicide Prevention Using Google Ads: Randomized Controlled Trial Measuring Engagement. *JMIR Mental Health*, 10, e42316–e42316. <https://doi.org/10.2196/42316>

Osborne, S. P., Radnor, Z., & Nasi, G. (2013). A New Theory for Public Service Management? Toward a (Public) Service-Dominant Approach. *American Review of Public Administration*, 43(2), 135–158. <https://doi.org/10.1177/0275074012466935>

Palmer, V. J., Weavell, W., Callander, R., Piper, D., Richard, L., Maher, L., Boyd, H., Herrman, H., Furler, J., Gunn, J., Iedema, R., & Robert, G. (2019). The Participatory Zeitgeist: an explanatory theoretical model of change in an era of coproduction and codesign in healthcare improvement. *Medical Humanities*, 45(3), 247–257. <https://doi.org/10.1136/medhum-2017-011398>

Palmer, V. J., Bibb, J., Lewis, M., Densley, K., Kritharidis, R., Dettmann, E., Sheehan, P., Daniell, A., Harding, B., Schipp, T., Dost, N., & McDonald, G. (2023). A co-design living labs philosophy of practice for end-to-end research design to translation with people with lived experience of mental ill-health and carer/family and kinship groups. *Frontiers in Public Health*, 11, 1206620–1206620. <https://doi.org/10.3389/fpubh.2023.1206620>

Palumbo, R. (2016). Contextualizing co-production of health care: a systematic literature review. *The International Journal of Public Sector Management*, 29(1), 72–90. <https://doi.org/10.1108/IJPSM-07-2015-0125>

Pearce, T., Maple, M., Wayland, S., McKay, K., Woodward, A., Brooks, A., & Shakeshaft, A. (2022). A mixed-methods systematic review of suicide prevention interventions involving multisectoral collaborations. *Health Research Policy and Systems*, 20(1), 40–40. <https://doi.org/10.1186/s12961-022-00835-0>

Piaget, J. (1973). *To Understand is to Invent: The Future of Education*. Penguin.

Pinfold, V., Szymczynska, P., Hamilton, S., Peacocke, R., Dean, S., Clewett, N., Manthorpe, J., & Larsen, J. (2015). Co-production in mental health research: reflections from the People Study. *Mental Health Review Journal*, 20(4), 220–231. <https://doi.org/10.1108/MHRJ-09-2015-0028>

Piper, D., Iedema, R., Gray, J., Verma, R., Holmes, L., & Manning, N. (2012). Utilizing experience-based co-design to improve the experience of patients accessing emergency departments in New South Wales public hospitals: An evaluation study. *Health Services Management Research: An Official Journal of the Association of University Programs in Health Administration*, 25(4), 162–172. <https://doi.org/10.1177/0951484812474247>

Pocobello, R., Sehity, T., Negrogno, L., Minervini, C., Guida, M., & Venerito, C. (2020). Comparison of a co-produced mental health service to traditional services: A co-produced mixed-methods cross-sectional study. *International Journal of Mental Health Nursing*, 29(3), 460–475. <https://doi.org/10.1111/inm.12681>

Pols, J., Althoff, B., & Bransen, E. (2017). The Limits of Autonomy: Ideals in Care for People with Learning Disabilities. *Medical Anthropology*, 36(8), 772–785. <https://doi.org/10.1080/01459740.2017.1367776>

Porche, M. V., Folk, J. B., Tolou-Shams, M., & Fortuna, L. R. (2022). Researchers' Perspectives on Digital Mental Health Intervention Co-Design With Marginalized Community Stakeholder

Youth and Families. *Frontiers in Psychiatry*, 13, 867460–867460.
<https://doi.org/10.3389/fpsy.2022.867460>

Proctor, E. K., Bungler, A. C., Lengnick-Hall, R., Gerke, D. R., Martin, J. K., Phillips, R. J., & Swanson, J. C. (2023). Ten years of implementation outcomes research: a scoping review. *Implementation Science: IS*, 18(1), 31–31. <https://doi.org/10.1186/s13012-023-01286-z>

Rebar, C.R., Gersch, C.J., Macnee, C.L., & McCabe, S. (2011). *Understanding Nursing Research* (3rd ed.). Lippincott Williams & Wilkins.

Ritchie, J., & Lewis, J. (Eds.). (2003). *Qualitative research practice: A guide for social science students and researchers*. SAGE Publications.

Robert G. (2013). Participatory action research: using experience-based co-design to improve the quality of healthcare services.
<http://dx.doi.org/10.1093/acprof:oso/9780199665372.003.0014>

Robert, G., Cornwell, J., Locock, L., Purushotham, A., Sturmey, G., & Gager, M. (2015). Patients and staff as codesigners of healthcare services. *BMJ (Online)*, 350, g7714–g7714. <https://doi.org/10.1136/bmj.g7714>

Robert G, Locock L, Williams O, Cornwell J, Donetto S, Goodrich J. (2022). *Co-Producing and Co-Designing*. Cambridge University Press.

Rose D, Thornicroft G. (2010). Service user perspectives on the impact of a mental illness diagnosis. *Epidemiol Psychiatr Soc.*;19(2):140-7. <https://doi: 10.1017/s1121189x00000841>.

Rose, D., & Kalathil, J. (2019). Power, privilege and knowledge: the untenable promise of co-production in mental 'health'. *Frontiers in Sociology*, 4, 57-. <https://doi.org/10.3389/fsoc.2019.00057>

Rosen, A., Gill, N. S., & Salvador-Carulla, L. (2020). The future of community psychiatry and community mental health services. *Current Opinion in Psychiatry*, 33(4), 375–390. <https://doi.org/10.1097/YCO.0000000000000620>

Saldaña, J. (2009). *The coding manual for qualitative researchers*. SAGE Publications.

Sanders, E. B.-N., & Stappers, P. J. (2008). Co-creation and the new landscapes of design. *CoDesign*, 4(1), 5–18. <https://doi.org/10.1080/15710880701875068>

Scanlan, J. N., Logan, A., Arblaster, K., Haracz, K., Fossey, E., Milbourn, B. T., Pépin, G., Machingura, T., Webster, J. S., Baker, A., Hancock, N., Miller, H., Simpson, D., Walder, K., Willcourt, E., Williams, A., & Wright, S. (2020). Mental health consumer involvement in occupational therapy education in Australia and Aotearoa New Zealand. *Australian Occupational Therapy Journal*, 67(1), 83–93. <https://doi.org/10.1111/1440-1630.12634>

Schubotz, D. (2019). *Participatory Research: Why and How to Involve People in Research* (1st ed.). SAGE Publications, Limited. <https://doi.org/10.4135/9781529799682>

- Sheikhan, N. Y., Kuluski, K., McKee, S., Hiebert, M., & Hawke, L. D. (2023). Exploring the impact of engagement in mental health and substance use research: A scoping review and thematic analysis. *Health Expectations : An International Journal of Public Participation in Health Care and Health Policy*, 26(5), 1806–1819. <https://doi.org/10.1111/hex.13779>
- Slattery, P., Saeri, A. K., & Bragge, P. (2020). Research co-design in health: a rapid overview of reviews. *Health Research Policy and Systems*, 18(1), 17–17. <https://doi.org/10.1186/s12961-020-0528-9>
- Slay, J., & Stephens, L. (2013). Co-production in mental health: A literature review. In *Policy File*. New Economics Foundation.
- Simons, H. (2009). *Case study research in practice*. SAGE Publications Ltd.
- Springham, N., & Robert, G. (2015). Experience based co-design reduces formal complaints on an acute mental health ward. *BMJ Quality Improvement Reports*, 4(1), u209153.w3970-. <https://doi.org/10.1136/bmjquality.u209153.w3970>
- Staley K, (2009). *Exploring Impact: Public Involvement in NHS, Public Health and Social Care Research*. INVOLVE, Eastleigh.
- Stake, R. E. (1995). *The art of case study research*. SAGE Publications.
- Steen, M. (2013). Co-Design as a Process of Joint Inquiry and Imagination. *Design Issues*, 29(2), 16–28. https://doi.org/10.1162/DESI_a_00207
- Strachan, G., Wright, G. D., & Hancock, E. (2007). An evaluation of a community health intervention programme aimed at improving health and wellbeing. *Health Education Journal*, 66(3), 277–285. <https://doi.org/10.1177/0017896907080135>
- Strandås, M., & Bondas, T. (2018). The nurse–patient relationship as a story of health enhancement in community care: A meta-ethnography. *Journal of Advanced Nursing*, 74(1), 11–22. <https://doi.org/10.1111/jan.13389>
- Swift, M. (2017). People powered primary care: learning from Halton. *Journal of Integrated Care (Brighton, England)*, 25(3), 162–173. <https://doi.org/10.1108/JICA-12-2016-0050>
- Tambuyzer, E., & Audenhove, C. (2015). Is perceived patient involvement in mental health care associated with satisfaction and empowerment? *Health Expectations : An International Journal of Public Participation in Health Care and Health Policy*, 18(4), 516–526. <https://doi.org/10.1111/hex.12052>
- Thomas, G., Lynch, M., & Spencer, L. H. (2021). A Systematic Review to Examine the Evidence in Developing Social Prescribing Interventions That Apply a Co-Productive, Co-Designed Approach to Improve Well-Being Outcomes in a Community Setting. *International Journal of Environmental Research and Public Health*, 18(8), 3896-. <https://doi.org/10.3390/ijerph18083896>
- Tindall, R. M., Ferris, M., Townsend, M., Boschert, G., & 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*, 30(6), 1693–1702. <https://doi.org/10.1111/inm.12925>

Tollyfield, R. (2014). Facilitating an accelerated experience-based co-design project. *British Journal of Nursing (Mark Allen Publishing)*, 23(3), 136–141. <https://doi.org/10.12968/bjon.2014.23.3.136>

Trischler, J., Dietrich, T., & Rundle-Thiele, S. (2019). Co-design: From expert- to user-driven ideas in public service design. *Public Management Review*, 21(11), 1595–1619. <https://doi.org/10.1080/14719037.2019.1619810>

Topor, A., & Ljungberg, A. (2016). “Everything is so relaxed and personal” - The construction of helpful relationships in individual placement and support. *American Journal of Psychiatric Rehabilitation*, 19(4), 275–293. <https://doi.org/10.1080/15487768.2016.1255276>

Vella-Brodrick, D., Patrick, K., Jacques-Hamilton, R., Ng, A., Chin, T.-C., O’Connor, M., Rickard, N., Cross, D., & Hattie, J. (2023). Youth experiences of co-designing a well-being intervention: reflections, learnings and recommendations. *Oxford Review of Education*, 49(6), 838–857. <https://doi.org/10.1080/03054985.2023.2194621>

Vennik, F. D., van de Bovenkamp, H. M., Putters, K., & Grit, K. J. (2016). Co-production in healthcare: rhetoric and practice. *International Review of Administrative Sciences*, 82(1), 150–168. <https://doi.org/10.1177/0020852315570553>

Verschuere, B., Vanleene, D., Steen, T., & Brandsen, T. (2018). Democratic Co-Production: Concepts and Determinants. In *Co-Production and Co-Creation* (1st ed., pp. 243–251). Routledge. <https://doi.org/10.4324/9781315204956-38>

Visser, M., ‘t Hart, N., Mul, M., & Weggelaar-Jansen, A. M. (2024). The Perspectives of Healthcare Professionals and Managers on Patient Involvement in Care Pathway Development: A Discourse Analysis. *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy*, 27(3), e14101-n/a. <https://doi.org/10.1111/hex.14101>

Vygotsky, L. S. (1978). *Mind in society: The development of higher psychological processes* (M. Cole, V. John-Steiner, S. Scribner, & E. Souberman, Eds. & Trans.). Harvard University Press.

Watson, F. A., Glascott, M., Eke, A., Hedgecock, L., Kelly, M. M., Saint, P., Singh, J., Small, V., Tasker, F., & Walker, G. (2022). Key stakeholder perspectives on expert-by-experience involvement in the values-based recruitment of student mental health nurses: A co-produced qualitative study. *Nurse Education Today*, 118, 105513–105513. <https://doi.org/10.1016/j.nedt.2022.105513>

Whitelaw, K., Seubert, L., Lee, K., Etherton-Bear, C., Clifford, R., Sheers, C., Loveny, J., & Brand, G. (2023). ‘Listening from a Personal Perspective’: Does Co-Designed Mental Health Education Shift Stigma? A Mixed Method Evaluation Study. *The British Journal of Social Work*, 53(2), 812–830. <https://doi.org/10.1093/bjsw/bcac155>

Widner, J., Woolcock, M., & Nieto, D. O. (Eds.). (2022). *The case for case studies: Methods and applications in international development*. Cambridge University Press.

Wilkinson, C., & McAndrew, S. (2008). "I'm not an outsider, I'm his mother!" A phenomenological enquiry into carer experiences of exclusion from acute psychiatric settings. *International Journal of Mental Health Nursing*, 17(6), 392–401. <https://doi.org/10.1111/j.1447-0349.2008.00574.x>

Williams, O., Sarre, S., Papoulias, S. C., Knowles, S., Robert, G., Beresford, P., Rose, D., Carr, S., Kaur, M., & Palmer, V. J. (2020). Lost in the shadows: reflections on the dark side of co-production. *Health Research Policy and Systems*, 18(1), 43–43. <https://doi.org/10.1186/s12961-020-00558-0>

World Health Organization (2015). WHO global strategy on people-centred and integrated health services: interim report. World Health Organization. <https://iris.who.int/handle/10665/155002>

World Health Organisation (2013). WHO Comprehensive Mental Health Action Plan 2013–2030 ISBN 978-92-4-003102-9.

World Health Organization (2009). Improving health systems and services for mental health. World Health Organization. https://iris.who.int/bitstream/handle/10665/44219/9789241598774_eng.pdf?sequence=1

Worthington, A., Rooney, P., & Hannan, R. (2012). *The triangle of care. Carers included: A guide to best practice in mental health care in England (2nd ed.)*. London: Carers Trust

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, 15(2), 215–228. <https://doi.org/10.1080/08870440008400302>

Yin, R. K. (2011). *Qualitative research from start to finish*. Guilford Press.

Yin, R. K. (2014). *Case study research: Design and methods* (5th ed.). SAGE Publications.

Zechmeister-Koss, I., Aufhammer, S., Bachler, H., Bauer, A., Bechter, P., Buchheim, A., Christiansen, H., Fischer, M., Franz, M., Fuchs, M., Goodyear, M., Gruber, N., Hofer, A., Hölzle, L., Juen, E., Papanthimou, F., Prokop, M., & Paul, J. L. (2023). Practices to support co-design processes: A case-study of co-designing a program for children with parents with a mental health problem in the Austrian region of Tyrol. *International Journal of Mental Health Nursing*, 32(1), 223–235. <https://doi.org/10.1111/inm.13078>

APPENDIX A: ETHICS APPROVAL



Janet Silvio <janet.silvio.22@um.edu.mt>

The status of your REDP form (FHS-2024-00197) has been updated to Approved

1 message

form.urec@um.edu.mt <form.urec@um.edu.mt>
To: janet.silvio.22@um.edu.mt

23 April 2025 at 09:22

Dear Janet Silvio,

Please note that the status of your REDP form (FHS-2024-00197) has been set to *Approved*.

You can keep track of your applications by visiting: <https://www.um.edu.mt/research/ethics/redp-form/frontEnd/>.

*****This email has been automatically generated by URECA. Please do not reply. If you wish to communicate with your F/REC please use the respective email address.*****